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Health and mortality

Report of the ACC Task Force on Basic Social Services for All

Summary

The present report has been prepared in response to resolutions 1995/55 and 1996/2 of the Economic and Social Council. It is based on the replies of 17 member organizations of the ACC Task Force on Basic Social Services for All to a request for information on the implementation of the Programme of Action of the International Conference on Population and Development with respect to the theme of the Commission on Population and development at its thirty-first session, "Health and mortality, with special emphasis on the linkages between health and development, and on gender and age".

The report presents an overview of the activities of the Task Force; discusses Task Force member organizations' work in the areas of primary health care, child survival and health, women's health and safe motherhood, and human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS); notes the technology, research and development work undertaken by Task Force member organizations; and concludes by highlighting key lessons learned through the experience of the Task Force.

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I. Introduction

1. The present report has been prepared in response to resolution 1995/55 of the Economic and Social Council, in which the Council endorsed the new terms of reference of the Commission on Population and Development, and resolution 1996/2, in which the Council welcomed the newly constituted Task Force on Basic Social Services for All of the Administrative Committee on Coordination (ACC), under the chairmanship of the United Nations Population Fund (UNFPA), and requested it to continue to report to the Commission on the implementation of the Programme of Action of the International Conference on Population and Development (ICPD). Under the topic-oriented and prioritized multi-year work programme of the Commission, the topic for 1998 is "Health and mortality, with special emphasis on the linkages between health and development, and on gender and age".

2. This report is based on responses received from 17 member organizations of the ACC Task Force[1] on Basic Social Services for All to a request for information on the implementation of the Programme of Action, with special emphasis on the theme of the year. Section II presents an overview of Task Force activities; section III focuses on primary health care and the health-care sector; section IV discusses child survival and health; section V examines women's health and safe motherhood; section VI focuses on human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS); section VII notes the technology, research and development work undertaken by Task Force member organizations; and section VIII concludes the report by highlighting key lessons learned through the experience of the Task Force.

II. Overview of Task Force activities

3. During 1997, the ACC Task Force on Basic Social Services for All focused its attention on producing the end products agreed to at its first meeting in February 1996. Using the modality of working groups with lead agencies, the Task Force has produced the following:

(a) Guidelines for the United Nations resident coordinator system on key areas of the Programme of Action — primary health care, reproductive health, national capacity-building in tracking child and maternal mortality, women's empowerment, basic education and guidance notes on international migration and development;

(b) A wall chart (available in United Nations languages) with key indicators to assist countries in monitoring progress in meeting conference goals in the provision of basic social services;

(c) An advocacy card on basic social services;

(d) A compendium of international commitments relevant to poverty and social integration;

(e) A report encompassing three country case studies on donor collaboration in assistance to the social sector and lessons learned/best practices.

The need for indicators

4. In response to the clear and felt needs of countries, the Task Force focused on developing a set of indicators to assist countries in monitoring their progress in achieving the goals agreed at the International Conference on Population and Development and other recent United Nations global conferences. In the first instance, the Task Force has developed and disseminated widely a wall chart on basic social services for all which can also be accessed via the Internet at **http://www.undp.org/popin/wdtrends/bss/bss.htm**, and all member organizations of the Task Force have been asked to link their websites to the wall chart website. In order to show where countries are currently and where they should aim to be in the future, the wall chart provides country data in six key areas: population; primary health care; nutrition; basic education; drinking water and sanitation; and shelter. The indicators pertaining to these will serve as a guide to assist countries in monitoring their progress in achieving conference goals. It should be noted that 8 of the indicators on the wall chart are the same as 8 of the 15 indicators in the Minimum National Social Data Set (MNSDS), endorsed by the Statistical Commission of the United Nations at its twenty-ninth session in February 1997.[2] Additionally, six of the seven ICPD-goal indicators selected by UNFPA for its revised approach to resource allocation to countries are the same as those on the wall chart. These indicators are related to access to reproductive health services; mortality reduction; and education, especially of women and girls.[3]

5. In April 1997, the World Health Organization (WHO), the lead agency of the Task Force's Working Group on Reproductive Health, organized a technical meeting on reproductive health indicators for global monitoring. The meeting, which brought together participants from developing countries, technical experts and representatives of United Nations agencies, focused on reaching consensus on 15 reproductive health indicators for national and global monitoring. The indicators meet certain essential criteria: they are considered to be ethical, useful, scientifically

robust, representative, understandable and accessible. They provide an overview of the reproductive health situation in different settings. It is not envisaged that they can provide all the information needed for national or global monitoring or for the evaluation of programme impact. For the latter, WHO advises that countries focus on strengthening national capacities for data generation, analysis and interpretation. To support countries in these endeavours, WHO has developed a guideline targeted to district health planners and managers which describes a process for the identification and selection of reproductive health indicators that meet essential criteria.

6. During 1996, UNFPA developed a list of quantitative and qualitative indicators that address the principal dimensions of reproductive health.[4] The list includes indicators that are primarily related to *outcome* (events) and *process* (delivery of services and management). The suggested indicators could be used for a variety of purposes, including monitoring the goals and targets set at the ICPD; assessing performance in delivery of reproductive health services; advocating for and developing policies in reproductive health; and programming and evaluating different components of reproductive health programmes. While the indicators are not intended to fulfil all possible data needs of policy makers and managers, those included have been selected so as to be manageable in most countries, though some may require complex collection instruments and procedures. A sub-set of indicators can be determined at the country level according to priority needs. Representatives from various bilateral agencies, United Nations agencies, non-governmental organizations and the UNFPA country support teams were involved in the process leading to the development of the set of indicators. In addition, UNFPA developed a framework of selected indicators to assess the impact of information/education/communication (IEC)/advocacy activities in support of population and reproductive health programmes; and indicators for population and development. These indicators, which have been published by UNFPA[5] will assist countries in monitoring their progress in achieving the goals of the International Conference on Population and Development.

Collaboration with non-governmental organizations and civil society

7. All member organizations of the Task Force on Basic Social Services for All have focused attention on strengthening and expanding their collaboration with non-governmental organizations, civil society organizations and the private sector. Strategic partnerships and close collaboration between all development partners are necessary. Thus, the United Nations resident coordinator system is encouraged to share all the end products of the Task Force with national counterparts, bilateral agencies, non-governmental organizations, civil society organizations and the private sector, and to seek their collaboration in activities focusing on achieving the goals of the International Conference on Population and Development and other recent United Nations global conferences.

III. Primary health care and the health-care sector

8. The concept of primary health care was defined and given international recognition at the International Conference on Primary Health Care (Alma Ata ,1978). The Declaration of Alma Ata,[6] adopted at the Conference, has become the main focus for the promotion of world health and the instrument for achieving the goal of health for all. Four basic components underlie the primary health care approach:

(a) Universal accessibility and coverage;

(b) Community and individual involvement;

(c) Intersectoral action for health;

(d) Appropriate technology and cost-effectiveness in relation to available resources.

The primary health-care approach received new impetus and reaffirmation at the International Conference on Population and Development. In keeping with the Declaration, the Programme of Action called on all countries to reduce mortality and morbidity and seek to make primary health care, including reproductive health care, available universally by the end of the current decade. The Programme of Action established specific time-bound goals, *inter alia*, for life expectancy, mortality, the provision of reproductive health and family planning services, and universal primary education.

9. The Programme of Action called on all countries to give priority to measures that improve the quality of life and health by ensuring a safe and sanitary living environment for all population groups. The expanding number of marginalized, underserved groups is a growing concern that needs to be addressed more carefully. Among those groups are the elderly, adolescents, poor women, the unemployed, the homeless, single mothers, indigenous people, and individuals and families in post-crisis or emergency situations. Special efforts are required to identify these groups and to meet their specific needs. Although some progress has been made, the current situation is that health-

care services often remain inaccessible to vulnerable groups, are fragmented and of poor quality, and do not meet the expectations of the clients. Moreover, in many developing countries there is still a strong urban bias in access to potable water, adequate sanitation and health clinics.

10. One encouraging development is that the focus is shifting from drinking-water quality alone towards overall environmental improvement involving water supplies, sanitation, hygiene education and general community involvement in environmental management. Another positive development is the notion of "healthy public policies" aimed at creating a healthy environment. WHO has undertaken a healthy cities programme which adopts a holistic approach to health development, focusing on the availability of clean water, sanitation, housing, environmental conditions and disease control. Already there are more than 2,500 healthy cities initiatives in action around the world. The healthy cities movement has proliferated to embrace healthy villages, healthy islands, health-promoting schools, healthy workplaces (with the accent on safety) and baby-friendly hospitals. These intersectoral projects lay great emphasis on health promotion and seek to make health issues understandable and relevant to the work of local governments and other bodies.

11. Migrants are not only a rapidly growing urban population but also a group with special health needs, including reproductive health and family planning needs. Research indicates that migrants and their families face greater health problems than long-term residents. Providing adequate reproductive health care to migrants requires more focused communication and service delivery. One way to serve migrants better is through community-based programmes that provide health care, including reproductive health care and family planning services, at locations where migrants work and congregate. International cooperation is also necessary to protect and promote the human rights of migrants.

12. The United Nations Centre for Human Settlements (Habitat) focuses on the identification and demonstration of viable solutions for integrated human settlements improvements at household and community levels aimed at improving health and the environment. Shelter-related hazards exact a heavy toll on human life, health and productivity in developing countries. The Settlement Infrastructure and Environment Programme (SIEP) of Habitat seeks to improve the interdisciplinary understanding of housing and health and to develop human settlements interventions that could promote community health and productivity. SIEP is working closely with the United Nations Children's Fund (UNICEF) in promoting child-friendly cities in developed and developing countries. This initiative aims at building capacity in authorities, local communities and non-governmental organizations with the aim of improving the well-being of children, especially in relation to basic services. The Habitat Agenda[7] identifies the well-being of children as the single most important indicator of good governance and healthy cities.

13. The United Nations International Drug Control Programme supports alternative development projects which aim to prevent, reduce or eradicate illicit drug production, while simultaneously offering alternatives and increased quality of life. They often include health components targeted at the general population, particularly women and children. Accompanying measures can include improvement of the nutritional base of the area and alternative agricultural development. Support is also provided for the training of health and social work professionals in the area of drug abuse treatment.

14. The International Labour Organization (ILO) provides technical assistance on the improvement of safety and health at work and on the design and management of health cost insurance schemes. Recently, ILO started an interregional project on social security in the informal sector. In one pilot project in Dar es Salaam, United Republic of Tanzania, for one dollar per person per month, participants are insured for primary health care and some secondary and tertiary-level health-care costs. This experiment, covering 1,500 workers, is self-financing and will be extended to other areas in the United Republic of Tanzania and to various areas in Benin, El Salvador and India. Similarly, the Bamako Initiative[8] has demonstrated that even poor families will pay modest charges for health care if the services needed are available and of good quality.

15. An important basic issue, which provides the framework within which all subsidiary issues in the health sector have to be addressed, is that of health sector reform. Health sector reform implies fundamental change in health-care systems and is a process of redefining the approaches required to achieve the objectives of primary health care and to improve and sustain health status. It must involve institutional change, as existing organizational structures and management systems have failed to address the major health sector problems in most developing countries. Reform is thus concerned with redefining priorities and policies and reforming the institutions through which the policies are implemented. There is no consistent, universal package of measures that constitutes health sector reform. Its agenda should therefore be country-specific, since different developing countries are at widely different stages in terms of health reform.

16. Selected key issues related to health sector reform are discussed in the guidelines on primary health care, prepared by the Task Force on Basic Social Services for All. They include the role of the ministry of health; planning and priority setting; decentralization of authority; health-care financing; human resource development; and capacity-building. Future action in the area of primary health care should build on opportunities provided in each country through governmental reform programmes in health, education, agriculture and other sectors; the mobilization of civil society and non-governmental organizations; and the initiatives of various United Nations theme groups at the country level. The Task Force guidelines highlight specific actions that can be undertaken at the country level through the United Nations resident coordinator system.

Elderly people and persons with disabilities

17. Declines in fertility levels and in mortality levels are producing fundamental changes in the age structure of the population of most societies, including, most notably, record increases in the proportion and number of elderly people. This steady increase of older age groups in national populations has significant implications for countries, particularly with regard to the future viability of existing formal and informal modalities for assistance to elderly people. In most societies, women, because they live longer than men, constitute the majority of the elderly population and, in many countries, elderly poor women are especially vulnerable. Since they live longer, women are more likely to be left without spousal or family support and face higher risks of health problems and disability. Also, as a result of their limited access to education and employment, women have fewer opportunities than men to earn and save money. Consequently, in old age many women are poor and without support or safety nets.

18. The Ageing and Health Programme of the World Health Organization has recently reviewed the health condition of ageing women in the world and has proposed a framework for action under the guidance of the WHO Global Commission on Women's Health. Together with WHO, the Division for the Advancement of Women of the United Nations Secretariat will hold an expert group meeting in June 1998, focusing on women and health. The meeting, which will develop proposals for gender-sensitive management systems in health care, will consider five themes: occupational health, environmental health, mental health, ageing, and nutrition. The Commission on the Status of Women will discuss the situation of elderly women at its forty-second session in 1998 and will focus on women and health at its forty-third session in 1999. To contribute to the International Year of Older Persons (1999), the Division for the Advancement of Women is carrying out a study on ageing women and development, based on country profiles. Recommendations emerging from the study will be made for policies to improve the situation of older women. With the United Nations programme on ageing of the Department of Economic and Social Affairs, an expert group meeting on gender and care giving was recently organized (Malta, 30 November-2 December 1997). Experts analysed current care giving patterns and policies from a gender perspective and explored innovative approaches to meeting the needs of women both as caregivers and as receivers of care.

19. Since 1989, UNFPA has collaborated with and provided support to the International Institute of Ageing, which was established in Malta in 1988, in response to Economic and Social Council resolution 1987/41. The main objective of the Institute is to fulfil the training needs of developing countries in the area of ageing and to act as a practical bridge between developed and developing countries in promoting technical cooperation, exchanging skills and knowledge and providing advisory services. The proposed training programmes and activities of INIA for 1996-1999 take into account the objectives and recommendations of the ICPD and the World Assembly on Ageing. Over the years, UNFPA support has helped to facilitate and contribute to the training of over 1,000 participants from developing countries, for courses on such subjects as demographic aspects and implications of population ageing, income security for older persons in developing countries, and gerontology and geriatrics. UNFPA has also provided support for updating the Institute's library and for the publication of a gerontological quarterly entitled *Bold*. UNFPA is also providing support to the Korea Institute for Health and Social Affairs for an international symposium to be held in 1998, in collaboration with the Government of the Republic of Korea, on population and development policies in low fertility countries: the challenges of changing age structures. With rapidly declining fertility and mortality, several Asian populations are experiencing substantial changes in age structure. One of the consequences of the changes is an increase in the number and proportion of the elderly. How to support and care for them is a challenge now facing the region, which the symposium will discuss.

20. Due to population ageing and the breakdown of traditional family structure, formal and informal support systems for the elderly are a major concern. Key actions are needed to:

(a) Develop systems of health care and of economic and social security in old age, with special attention to the needs of women;

(b) Enhance the self-reliance of elderly people, promote their quality of life and enable them to work and live independently;

(c) Develop a social support system, both formal and informal, to enhance the ability of families to take care of elderly people within the family.

21. In 1996, the International Labour Organization published a study entitled *Combining Work and Elder Care: A Challenge for Now and the Future*, which examines the relevant international instruments and policies regarding elder care and compares the approaches to supporting workers with elder-care responsibilities in six industrialized countries. The Economic and Social Commission for Asia and the Pacific is currently supporting small-scale surveys of household structure and the elderly in Bangladesh, China, Indonesia, Pakistan, Sri Lanka, Thailand and Uzbekistan. The results will be published in 1998. The United Nations High Commissioner for Refugees (UNHCR), on the occasion of the International Day of Older Persons, noted the invisibility of older persons, even though, as in the Great Lakes area of Central Africa, they make up about 10 per cent of the refugee camp population. Particularly vulnerable are old people who are alone or who care for young children. UNHCR highlights the need for inclusion of the elderly and respect for their skills and knowledge. It encourages agencies to establish systems of home visits and neighbour support so that elderly people can be helped to obtain the basic necessities of life and access to health care.

22. The valuable contribution that elderly people make to families and society, especially as volunteers and caregivers, should be given due recognition and encouragement. As underscored in the Programme of Action, Governments, in collaboration with non-governmental organizations and the private sector, need to strengthen formal and informal support systems and safety nets for elderly people and eliminate all forms of violence and discrimination against elderly people, paying special attention to the needs of women. The United Nations system could provide assistance in these endeavours.

23. In spite of social, scientific and technological advances, there remains a pressing need for continued action to promote effective measures for the prevention of disability, for rehabilitation and for the realization of the goals of full participation and equality for persons with disabilities. The Programme of Action calls on Governments at all levels to consider the needs of persons with disabilities in ethical and human rights terms and to develop the infrastructure to address those needs, in particular with regard to education, training and rehabilitation. In 1996, WHO and UNHCR held a joint workshop in Uganda with the Norwegian Association of the Disabled. The workshop brought together representation from refugees, non-governmental organizations, UNHCR and governmental officials from several countries in the region to draw up plans of action on community-based rehabilitation. The ideas generated at the workshop have been taken back to Rwanda, Ethiopia, Kenya and the United Republic of Tanzania, where the inspiring Uganda model (the country even has a quota for disabled persons in Parliament) is being applied. The workshop highlighted the fact that while various health interventions are required for disability, one major problem is community acceptance of those with disability.

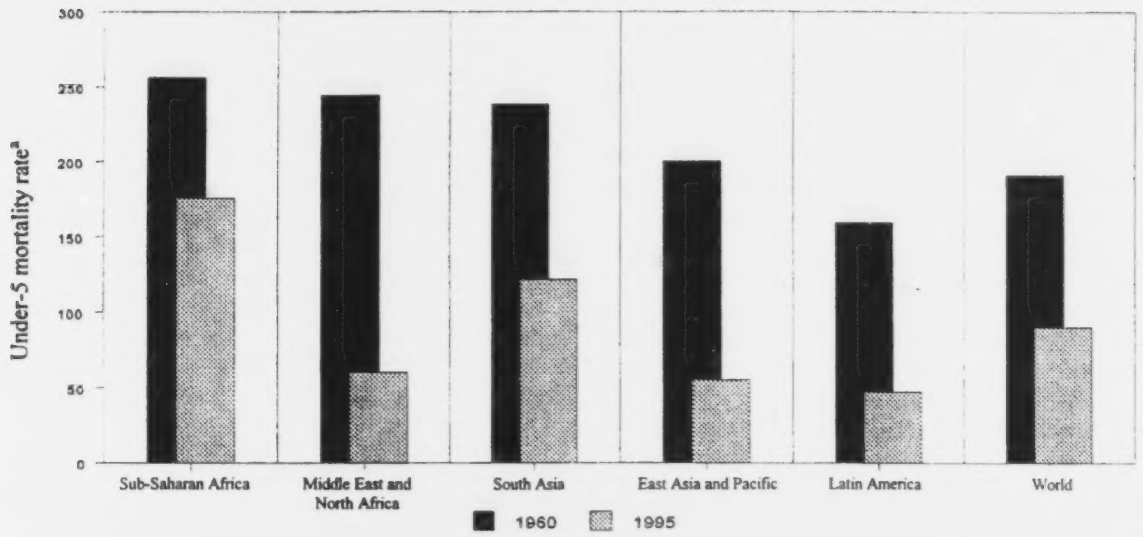
IV. Child survival and health

24. Globally, over the past 30 years, the average infant and under-5 mortality rates have dropped by half or more, in great part, through the control of childhood communicable diseases and reductions in perinatal deaths (see figure). Such extraordinary reductions in mortality are unmatched in recorded history. The current average global infant mortality rate (IMR) — the ratio of deaths of children under one year to annual total live births — is 61, down from 123 in the mid 1960s. Similarly, the under-5 mortality rate (U5MR) dropped to 90, from 191 in the mid 1960s.

25. However, despite significant gains made over the past few decades, childhood mortality risks remain high throughout the developing world, particularly in sub-Saharan Africa and South Asia. Most of the deaths are preventable. Diarrhoea and acute respiratory infections together account for 38 per cent, vaccine-preventable disease for 13 per cent, and neonatal and perinatal crises for almost 18 per cent, exacerbated in more than half the cases by malnutrition. HIV/AIDS has eroded or reversed many hard-won gains in sub-Saharan Africa and now threatens South Asia and South-East Asia. Experience has shown that community and household participation is crucial in activities for child survival. The quality of services has to be improved. District health systems need to be decentralized and strengthened. Health services and programmes must reach inaccessible and vulnerable groups, and gender bias in health services must be eliminated.

26. UNICEF estimates that about 7 million young lives are being saved each year as a result of the cumulative impact of several interventions that were begun after the 1990

Figure. Under-5 mortality rate, 1960 and 1995



Source: The State of the World's Children, 1997 (New York, Oxford University Press, 1997), table 10.

[a] Probability of dying between birth and exactly 5 years of age, expressed per 1,000 live births.

World Summit for Children and reinforced by the International Conference on Population and Development. This dramatic decline in the infant mortality and under-5 mortality rates is the outcome of a number of collective, reinforcing efforts. Governments have moved to accord high priority to child survival and health; the work of non-governmental organizations and of the private sector has expanded; community participation has increased, and families have been empowered by gaining greater knowledge and skills about utilizing low-cost, easily available life-saving technologies for their children; bilateral and multilateral agencies have mobilized greater resources for child survival and health interventions; and immunization, nutrition and reproductive health programmes have expanded. Many of these efforts were spearheaded by United Nations agencies, in partnership with Governments, non-governmental organizations, service organizations, and bilateral and multilateral donors.

27. Improving the health of the world's children is central to UNICEF's mission, and the reduction of infant, child and maternal mortality is the overarching goal of its health and nutrition programmes. UNICEF seeks to address the basic socio-economic causes of poor health and child deaths in a multisectoral way. With its direct programme interventions, UNICEF provides support to efforts to extend universal primary education, expand the availability of potable water and improve primary environmental care, and improve household food security and access to other resources. Through advocacy, it raises awareness about the situation of children, reinforces political will for action, influences policies and helps to establish a moral environment that puts the well-being of children high on the political agenda. The rights to survival and to the highest attainable standard of health, articulated in the Convention on the Rights of the Child, adopted by the General Assembly in 1989[9] and ratified nearly universally since then, provide the framework for UNICEF's work in mortality reduction. The UNICEF approach to health places the family and the household at the centre of health action and the child at the centre of the family. The focus is on helping to strengthen countries' capacities in health monitoring, health promotion and essential health services within the primary health-care approach so that children may enjoy the highest attainable standard of health and nutrition.

28. Child immunization has been one of the key public health interventions supported by UNICEF for the past 15 years. Over 80 per cent of the world's children are now covered by immunization services, up from 15 per cent or less in many parts of the world just a decade ago. At current levels of immunization, almost 3 million children are saved

annually. But there are still 2 million children dying because they are not immunized. The burden of immunizable/preventable diseases is greatest in sub-Saharan Africa, a result of low immunization coverage and poor health infrastructure. Despite significant increases in immunization coverage in the past decade, measles remains a major cause of childhood death and ill health in many developing countries. WHO estimates that measles alone accounts for more children's deaths than any other vaccine-preventable disease. Acute respiratory infections, especially pneumonia, are another major cause of illness and childhood mortality, accounting for almost 2 million under-5 deaths and 30-40 per cent of paediatric visits to health facilities.

29. Oral rehydration therapy is being used in almost every country in the developing world to prevent dehydration and death from diarrhoeal diseases. Polio and guinea worm disease are on the verge of eradication. An additional 1.5 billion people have begun consuming iodized salt, protecting around 12 million infants each year from mental retardation. Over 12,000 hospitals are designated baby-friendly as a result of efforts to promote breastfeeding, which is fundamental to survival, health, nutrition and the development of children and is specifically recognized in article 24 of the Convention on the Rights of the Child as a major factor in ensuring the child's right to the highest attainable standard of health. Public communication and advocacy for breastfeeding have been carried out in collaboration with many Governments and non-governmental organizations.

30. An estimated 174 million under-5 children in the developing countries are malnourished, measured by weight for age. Some 247 million are estimated to be stunted. A study funded by UNICEF, the results of which were endorsed by WHO, concluded that, globally, malnutrition contributes to about 56 per cent of under-5 mortality, both directly and indirectly, by lowering resistance to infectious illness. Malnutrition also results in poor physical and cognitive development. There is increasing evidence to suggest that malnutrition in the early years of life increases the risk in adulthood of diabetes, cardiovascular disease and other chronic illnesses.

31. Promotion of the improvement in the health and nutritional status of infants and children and pregnant and nursing mothers is the key operational feature of the work of the World Food Programme (WFP). The major form of WFP's intervention is supplementary feeding programmes and the incentive they provide for more regular utilization of mother and child health (MCH) services. To combat micronutrient deficiencies, WFP is providing low-cost blended foods fortified with essential micronutrients. The evidence indicates that supplementary feeding projects have clearly contributed to greater enrolment in MCH programmes and regular monitoring of pregnant women and children. Most projects are designed to reach between 20,000 and 100,000 beneficiaries per annum; seven projects target more than 200,000 people each year. The ongoing 27 supplementary feeding interventions carry a commitment value of over $300 million.

32. The Food and Agriculture Organization of the United Nations (FAO) provides technical guidance for promoting household and community action to improve dietary intake and nutritional well-being. FAO supports community-based participatory methods for achieving and sustaining nutritional improvements, especially among vulnerable population groups; increasing the utilization of locally available food crops; and improving the nutritional impact of post-emergency and agricultural rehabilitation programmes and food assisted projects. Training workshops are also supported to assist in national capacity-building for the execution of these activities at the community level in member countries.

33. UNDCP cooperates with WHO, UNICEF and the Joint United Nations Programme on AIDS (UNAIDS) in promoting comprehensive drug abuse prevention programmes that address the health and education needs of youth at risk. The target groups of such interventions — in-school and out-of-school youth, street children and young working adults — are individuals who have never used drugs; those who are occasional or frequent users; and those who abuse drugs regularly. Early preventive interventions aim at tackling the root causes of drug abuse by strengthening families and communities and providing basic social services.

34. The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services. The Programme of Action underscores that information and services should be made available to adolescents to help them understand their sexuality and to protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction. Since the International Conference on Population and Development, UNFPA has focused increasing attention on the key area of adolescent reproductive health, through collaboration with such non-governmental organizations as the International Planned Parenthood Federation. Recently, in collaboration with another non-governmental organization, the Centre for

Development and Population Activities, UNFPA organized the African Youth Forum on Adolescent Reproductive Health, held in Addis Ababa, Ethiopia. UNFPA also sponsored an international youth essay contest on promoting responsible reproductive health behaviour.

V. Women's health and safe motherhood

35. The Programme of Action calls on all countries to strive to effect significant reductions in maternal mortality by the year 2015 — a reduction in maternal mortality of one half of the 1990 levels by the year 2000, and a further one half by 2015. At the global level, it has been estimated that more than half a million women die each year of pregnancy-related causes, 99 per cent of them in developing countries. The gap between developed and developing countries is wide and should be narrowed. Programmes to reduce maternal morbidity and mortality should include information and reproductive health services, including family planning services. Priority should be accorded to improving the nutritional and health status of young women through education and training as part of maternal health and safe motherhood programmes. Programmes and education to engage men's support for maternal health and safe motherhood should be developed. Women should have access to quality services for the complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly. Adolescent females and males should be provided with information, education and counselling to help them delay early family formation, premature sexual activity and first pregnancy. Strategies should be devised to ensure that men share responsibility for sexual and reproductive health, including family planning, and for preventing and controlling sexually transmitted diseases, HIV infection and AIDS.

36. Women bear by far the greatest burden of reproductive health problems but biological factors alone do not explain women's disparate burden. Their social, economic and political disadvantages and the denial of their reproductive rights have a detrimental impact on their reproductive health. The empowerment of women is a fundamental prerequisite for their reproductive health; women's reproductive health will not be significantly improved in the absence of gender equity and equality. Because men's social and sexual behaviour directly affects women's reproductive health, reproductive health programmes, while catering for the specific needs of women, will also need to pay special attention to the roles and responsibilities of men and the need for them to assume greater responsibility for their sexual and reproductive behaviour and their social and family roles.

37. The Task Force guidelines on primary health care, reproductive health and women's empowerment underscore the need for a gender approach in addressing women's health and safe motherhood issues. A gender approach to health (research, policies and programmes) examines how gender differences determine differential exposure to risk, access to information, services and benefits of technology and provides significant insights into the design of programmes and practical disease control interventions. A "gender lens" needs to be applied in viewing all aspects of primary health care, taking into account the multiple roles and the position of women and men, and how this affects the issue in question. Collecting sex- and age-disaggregated data is essential for this kind of analysis — for example, to determine whether there are differences in malnutrition or immunization rates between girls and boys, or to identify the problems related to accessibility to basic social services and to food and water.

38. The Safe Motherhood Initiative co-sponsored by WHO, UNICEF, UNFPA, the World Bank and two non-governmental organizations, the International Planned Parenthood Federation and the Population Council, focuses on five key areas of action: advocacy; epidemiological, social and operational research; information dissemination; human resource development; and health service improvement measures. In October 1997, a technical consultation on safe motherhood was held in Sri Lanka to review progress made to date on this important aspect of reproductive health.

39. Maternal health has been a growing focus for UNICEF, with key interventions directed at the reduction of maternal and neonatal mortality, including improvements in perinatal care, maternal nutrition and access to expanded reproductive health care. Process indicators for the reduction of maternal mortality are currently being developed in partnership with WHO, bilateral donors and experts in developing countries. WHO and UNFPA have been partners in UNICEF's work related to maternal health and survival. WHO as the technical agency provides the standardized instruments (needs assessment, training modules). UNFPA is the lead agency for integration of reproductive health care, which includes sexual health and family planning, maternal and neonatal care, prevention and treatment of reproductive tract infections, sexually transmitted diseases, including HIV/AIDS, and elimination of harmful practices, including female genital mutilation (FGM) and violence against women.

40. The Programme of Action underscored that in a number of countries, harmful practices meant to control women's sexuality have led to great suffering. Among them is the practice of female genital mutilation, which is a violation of basic rights and a major lifelong risk to women's health. It is estimated that 85-115 million girls have undergone some form of genital mutilation, and at least 2 million girls a year are at risk .UNFPA is addressing the issue of FGM. In 1996 it sponsored a technical consultation in Ethiopia, with representatives from 25 countries, to discuss, *inter alia*, the types of training, research and services needed to eradicate female genital mutilation. The recent dramatic success of a UNFPA-supported programme in Kapchorwa district in Uganda underscores the potential impact that advocacy can have. The Reproductive Educative and Community Health (REACH) Programme of Kapchorwa district uses an innovative and culturally sensitive approach in which community-based agents involve community leaders and people from all sectors of society in sensitization seminars and workshops to make them aware of the harmful aspects of FGM. The REACH Programme has witnessed a 36 per cent drop in female circumcision in less than one year.[10]

41. The view that violence against women is a universal obstacle to development and to empowerment of women underpins the work of the United Nations Development Fund for Women (UNIFEM). In support of actions to eliminate violence against women, the Administrator of UNDP has established a trust fund within the existing mandate of UNIFEM. The Governments of Australia, Denmark, Italy, Japan, the Republic of Korea, Malta and Mauritius have already contributed to the trust fund. Twenty-five initiatives in Africa, Asia and the Pacific and Latin America have been funded, with a total of over $850,000. UNFPA has pooled its gender advisers with UNIFEM, and UNDP is planning to do the same. UNICEF, UNFPA and WHO in partnership with other United Nations agencies and non-governmental organizations are developing strategies to address women's health problems such as domestic violence, women's vulnerability to HIV/AIDS, and harmful practices affecting women and girls, such as FGM.

42. Special efforts are needed to protect and promote the human rights of women migrants and refugees, who are especially vulnerable to violence and exploitation because of their gender. In 1996, UNFPA funded an emergency reproductive health-care initiative for refugees in the Great Lakes area of Central Africa to benefit some 200,000 women. The project was executed and coordinated by the International Federation of Red Cross and Red Crescent Societies, in full cooperation with UNHCR and non-governmental organizations. This collaborative effort marked the first time that reproductive health-care services for refugees had been planned at the beginning of an emergency operation.

43. The Department of Humanitarian Affairs of the United Nations Secretariat reports that the denial of access of girls and women to education and health services became prominent soon after the arrival in 1994 of the Taliban, in the Kandahar region of Afghanistan. In response to these clear violations of human rights, the United Nations resident and humanitarian coordinators for Afghanistan focused on the issue in the drafting of the country strategy note. The resident coordinator also provided funding for the creation of a gender advisory group, with the participation of non-governmental organization participation. At the meeting of the Afghanistan Support Group, held in Ashkabad, Turkmenistan, on 21-22 January 1997, the gender issue was singled out as the overriding problem affecting all aspects of the humanitarian assistance programme. Since then, donors, United Nations agencies and non-governmental organizations have intensified their efforts to take a common stand against the violation of the rights of girls and women to education and health care.

44. In 1999, when the International Labour Conference convenes, delegates will consider the revision of the Maternity Protection Convention (No. 103), 1952. Among the minimum standards set by the Convention are the right to 12 week's maternity leave with cash and medical benefits, the right to nursing breaks, and protection against dismissal while on maternity leave. ILO has prepared a law and practice report which examines the principal aspects of maternity protection provisions in countries around the world. The rights to maternity leave, to income replacement during leave, and prenatal confinement and post-natal care are fundamental to promoting the health, safe motherhood and economic well-being of pregnant and nursing workers. Ensuring that such workers are not subjected to discriminatory treatment in employment enables them to enjoy these rights.

45. The Programme of Action calls for recognizing and supporting the role of women as primary custodians of family health. Access to basic health care, expanded health education, the availability of simple cost-effective remedies, and the reappraisal of primary health-care services, including reproductive health-care services to facilitate the proper use of women's time, should be provided. It is critical that reproductive health programmes emphasize the empowerment of women and specifically address the special needs of girls and women as well as those of other underserved groups, such as youth and adolescents, rural and

urban poor, persons in remote or neglected areas, and migrants, refugees and displaced persons. Increasing the role and responsibility of men in reproductive health, parenting and the prevention of STD/AIDS will also have a positive impact on the health of women. Attention must also continue to be focused on eradicating gender-based violence and other harmful practices detrimental to the health and well-being of girls and women. Women must also be afforded opportunities to be involved in the design, development, implementation and evaluation of reproductive health programmes. The United Nations resident coordinator system can play a key role in ensuring that development programmes emphasize the empowerment of women and focus attention on promoting and enhancing their reproductive health. The guidelines developed by the Task Force on Basic Social Services for All provide a practical tool for such programming and advocacy.

VI. Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS)

46. As underscored in the Programme of Action of the International Conference on Population and Development, the HIV/AIDS pandemic is a major concern for both developed and developing countries. Of the estimated worldwide total of 30.6 million living with HIV/AIDS, 29.5 million are adults and 1.1 million are children. According to recent estimates by the Joint United Nations Programme on AIDS (UNAIDS) and WHO, the epidemic continued to expand in 1997, with an estimated 5.8 million new HIV infections — approximately 16,000 a day. Over 40 per cent of the new infections among adults occurred in women. The majority of newly infected adults are under 25 years old. During 1997, HIV/AIDS-associated illnesses caused the death of an estimated 2.3 million people, including 460,000 children. This represents about a fifth of the total 11.7 million AIDS deaths since the beginning of the epidemic in the late 1970s.[11]

47. The HIV/AIDS pandemic is not just a serious health challenge; it is a critical human development challenge with complex socio-economic impacts and costs. Loss of experienced personnel and skilled labour, declines in productivity, the need for increased resources to hire and retrain replacements, increased absenteeism and labour turnover, increased health-care costs, coupled with the human and social costs endured by the individuals and communities affected by the pandemic are imposing heavy burdens, particularly on developing countries with limited resources.

48. In the absence of a vaccine, education and communication strategies, the provision of condoms, information and counselling, the promotion of safe and responsible behaviour and ensuring universal precautions in health settings are critical components of HIV/AIDS prevention and control strategies. In particular, special attention should be focused on reaching those at high risk of acquiring HIV infection, including adolescents and women, whose vulnerability is often greatest.

49. The Joint United Nations Programme on AIDS (UNAIDS), operational since January 1996, serves as the main advocate for global action on HIV/AIDS, pooling the experiences, efforts and resources of its six co-sponsors: UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank. The strategic focus of UNAIDS is to strengthen the capacity of the United Nations system to assist Governments and civil society to respond to HIV/AIDS; to build worldwide political commitment and support to respond to HIV/AIDS; and to improve the content, access and use of the body of knowledge needed to accelerate the global response to HIV/AIDS. The six co-sponsors of UNAIDS are also members of the Task Force on Basic Social Services for All. In addition to collaborative efforts under the UNAIDS umbrella, the six co-sponsors carry out activities under their own mandates.

50. UNFPA, through its reproductive health and family planning programmes is providing assistance for HIV/AIDS prevention activities in 124 countries. This support focuses on four main areas: supply and distribution of condoms; training of reproductive health and family planning information and service providers; HIV/AIDS education, in and out of school; and HIV/AIDS information as part of broader population/reproductive health information, education and communication programmes. During 1996, in providing support to national AIDS prevention and control programmes, UNFPA collaborated with 115 non-governmental organizations and supported activities aimed at youth and adolescents in 95 countries. UNFPA estimated that the extent of its total support for HIV/AIDS prevention in 1996 was $20.5 million, and 95 per cent of that — i.e., $19.5 million — was at the country level. UNFPA continues to be an active co-sponsor of UNAIDS and works closely through the Programme Coordinating Board, the Committee of Co-sponsoring Organizations and various technical and theme groups which have been set up. At the country level, a number of the United Nations theme groups have been chaired by UNFPA representatives.

51. As a co-sponsor of UNAIDS, the World Bank is a leader in funding of HIV/AIDS programmes and links its efforts to broader initiatives in reproductive health and the control of communicable diseases, particularly reproductive tract infections and sexually transmitted diseases. The United Nations Educational and Scientific and Cultural Organization (UNESCO) is also a co-sponsor of UNAIDS; its initiatives on HIV/AIDS prevention are primarily focused on education, both in formal and non-formal settings. They include: development of new teaching/learning materials on HIV/AIDS prevention; revision of school curricula; teacher training; training of representatives of grass-roots women's organizations; and regional seminars for high-level decision makers. The United Nations Development Programme (UNDP), also a co-sponsor of UNAIDS, is focusing on integrating HIV/AIDS prevention activities in key programming areas, including governance, gender and poverty. Training workshops have been organized in country offices to strengthen programming skills of national focal points. Meanwhile, the United Nations Development Fund for Women (UNIFEM) is working with other United Nations agencies and non-governmental organizations, at the field level, on women's empowerment aspects of HIV/AIDS projects.

52. The United Nations Children's Fund (UNICEF) is also a co-sponsor of UNAIDS. Using a rights-based approach, its focus is on strengthening capacity for measuring young people's health and development; protecting their rights to access information and services, including sexual and reproductive health services; identifying and developing resources to support country programmes; and improving the flow of information within UNICEF and with its partners. The main focus of UNICEF's global efforts is to distil and promote country and regional "best practice" experience in the use of communication for behaviour change in HIV/AIDS prevention, care and rights, and to mobilize partners to expand their priorities on HIV/AIDS issues. UNICEF is also very active in the theme groups at the country level.

53. The United Nations International Drug Control Programme, in collaboration with ESCAP, UNAIDS, local Governments and various non-governmental organizations is active in preventing HIV infection and providing care for injecting drug users, including those in the Golden Triangle area in South-East Asia. The United Nations Industrial Development Organization (UNIDO) has implemented HIV/AIDS prevention projects in sub-Saharan Africa, to meet the combined objectives of industrial development and the prevention of the spread of HIV/AIDS. UNIDO is supporting improved access to and affordability of products used in prevention programmes — condoms, latex gloves, syringes, HIV-1/2 test kits — through development of local manufacturing capability. Local manufacturers are also being encouraged to carry specific HIV/AIDS prevention messages on their product labels. HIV/AIDS prevention education is also being imparted to Palestinian school children, trainees at vocational centres, and refugee women, through a programme undertaken by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

54. In the fight against HIV/AIDS, two key areas require critical attention: prevention among women and children — two of the most vulnerable groups; and increasing access to HIV/AIDS-related drugs and treatments in developing countries. The disastrous impact of HIV/AIDS on children needs to be urgently addressed. If the spread of HIV is not rapidly contained, the gains made in reducing infant and child death rates will be reversed in many countries. Estimates in a recent report, entitled *Children Living in a World with AIDS*, released by UNAIDS in June 1997,[12] indicate that by the year 2010, AIDS may increase infant mortality by as much as 75 per cent and under-5 child mortality by more than 100 per cent, in the most hard-hit countries in the world. According to the report, more children than ever before are contracting HIV, and there is no sign that the infection rate is slowing. Women of child-bearing age now make up an ever-increasing proportion of people with HIV worldwide; for example, AIDS kills more women than men in sub-Saharan Africa.

55. Reducing the vulnerability of infants to HIV infection also requires increasing women's control over their situations, improving their ability to negotiate with their male partners regarding their own reproductive and sexual health, increasing their access to health services and increasing the knowledge and sense of responsibility of both men and women about HIV prevention. It also requires increasing women's access to antiviral drug regimens which can cut the risk of mother-to-child transmission. In November 1997, UNAIDS launched the pilot phase of the UNAIDS HIV Drug Access Initiative, a collaborative effort between the public and private sectors to identify strategies to increase access to HIV/AIDS drugs in developing countries. The four developing countries involved in the pilot phase — Chile, Côte d'Ivoire, Uganda and Viet Nam — will work to adapt their health infrastructures to ensure effective distribution and uses of HIV/AIDS-related drugs, and participating pharmaceutical and diagnostic companies will subsidize purchase of the drugs. The overall objective of the initiative is to provide improved care and increase access to the newest and most effective drugs.

56. When an HIV diagnosis occurs, the family and the entire household often suffer from stigma, isolation, job loss and impoverishment because of discrimination, resulting frequently from fear and/or incorrect information and beliefs about HIV transmission. These prejudices and their cruel consequences must be combated and United Nations agencies and organizations are uniquely positioned to mount education and awareness-raising campaigns which will counter such discrimination. The Programme of Action specifically calls on Governments to develop policies and guidelines to protect the individual rights of persons infected with HIV and their families and eliminate discrimination against them. Special programmes should also be devised to provide care and the necessary emotional support to those who are affected and to counsel their families and near relations.

VII. Technology, research and development

57. Member organizations of the Task Force on Basic Social Services for All, in keeping with the call of the Programme of Action and their own mandates, are continuing activities pertaining to basic data collection, analysis and dissemination; reproductive health research, and social and economic research. The International Monetary Fund, recognizing the need to improve data collection on governmental spending in the social sector, particularly on health and education, has intensified its collaboration with the World Bank in monitoring public expenditures of member countries. This focus reflects a recognition of the crucial link between the level and efficiency of health and education spending and economic growth. The new emphasis was also prompted by the IMF Executive Board's request that staff pay particular attention to social indicators in the contexts of adjustment programmes supported by the IMF's enhanced structural adjustment facility and of the initiative to help heavily indebted poor countries achieve sustainable external debt positions. IMF has underscored that the proper mix of monetary and fiscal policies and the structural reforms needed to underpin them should also take into account the poor and the most vulnerable people in society. The second generation of reforms promoted by IMF seeks to enhance growth, accelerate human development, and ensure that the benefits of growth are widely shared. Thus, countries are encouraged to ensure adequate public expenditures for education and health to help individuals realize their potential to participate actively in a market economy and provide social protection to those who bear the brunt of the changes of a dynamic economy.

58. The Population Division (Department of Economic and Social Affairs, United Nations Secretariat) continually undertakes research and other activities related to health and mortality, monitoring levels and trends of mortality at the global level and studying its causes and consequences; monitoring country policies and programmes related to various aspects of health and mortality; and as part of the biennial revision of the United Nations world population estimates and projections, maintaining and updating the official United Nations estimates of life expectancy at birth and infant and child mortality for all countries of the world. For the thirty-first session of the Commission on Population and Development, the Population Division has prepared the 1998 edition of *World Population Monitoring* which covers health and mortality, with special emphasis on the linkages between health and development and on gender and age. As part of the biennial revisions of *World Population Prospects*, estimates are available of the effect of HIV/AIDS on deaths, life expectancy at birth, infant mortality and population growth. For the *1996 Revision*, the impact of the HIV/AIDS pandemic was measured for 24 African countries, two Asian countries and two Latin American countries. The Economic Commission for Latin America and the Caribbean collaborated with UNICEF and the Population Division in monitoring infant and child mortality rates in Latin American countries. Mortality estimates have been provided for urban and rural areas, disaggregated by level of education of the mother.

59. The Economic Commission for Europe (ECE) is carrying out a study of demographic change in European countries with economies in transition, which is part of the UNFPA-supported programme of data collection, analysis and research, focusing on selected aspects of the implementation of the Programme of Action in the ECE region, particularly in central and eastern Europe. The study is concerned, *inter alia*, with the trends and patterns in overall mortality, change in mortality by age and gender, and causes of mortality differentials. Early results indicate that during the transition to democracy and a market economy, the European Soviet successor States experienced losses in male and female life expectancy at birth, while as a rule, central European and Balkan countries witnessed gains. Deterioration in male survival in the former Soviet Union has been far greater than that in female survival, bringing about unprecedented sex differentials in mortality, particularly in the Russian Federation and the Baltic countries. Children and adolescents, both male and female, generally enjoyed improvements in survival during the

transition years. Working-age adults and older persons were less fortunate. Their mortality declined in central Europe but generally increased elsewhere, particularly in the former Soviet Union. The mortality increases among adult males have been far greater than those among adult females, however, and the greatest mortality increases have taken place among older women and men.

60. The Programme of Action calls for the elimination of excess mortality of girls where it exists and for special education and public information efforts to promote equal treatment of girls and boys with respect to nutrition and health care. In response to those concerns and the need to identify measures aimed at eliminating excess and preventable mortality among young girls, a study was undertaken by the Population Division on the sex differentials in infant, child and under-5 mortality and the specific mechanisms that may lead to excess female mortality in childhood. The study *Too Young to Die: Genes or Gender*, discusses the measurement and analysis of levels and trends of childhood mortality for boys and girls and explores the broad range of mechanisms that influence sex differentials in child mortality.

61. UNFPA, under its Global Initiative on Contraceptive Requirements and Logistics Management Needs, conducted a number of in-depth studies in developing countries, in collaboration with other United Nations agencies, bilateral agencies and selected international non-governmental organizations. The studies were carried out with the full cooperation of Governments in Bangladesh, Brazil, Egypt, India, Mexico, Nepal, the Philippines, Pakistan, Turkey, Viet Nam and Zimbabwe. Subsequently, studies were also undertaken in Burkina Faso, the Dominican Republic, Ethiopia, Haiti, and Morocco. In addition to projecting contraceptive requirements to the year 2005, the studies identified programme needs for logistics management, assessed the role of non-governmental organizations and the private sector in family planning activities and contraceptive delivery, reviewed the feasibility of local production of contraceptives, examined trends in the sources and uses of funds for contraceptive commodities and logistics management, and estimated condom requirements for the prevention and control of sexually transmitted disease/acquired immunodeficiency syndrome. A facility has been established at UNFPA to assist countries in meeting their emergency needs for contraceptive commodities. Interim stockholdings have been established of all primary contraceptive methods in order to respond to envisaged emergency demand.

62. The WHO Special Programme on Research, Development and Research Training in Human Reproduction has developed and tested a new strategy to strengthen country capacity to broaden contraceptive choice. The Programme played a critical role in the identification of levonrgestrel as a novel method of emergency contraception. It is being implemented in model programmes in a number of countries. Ongoing activities include improving access to once-a-month injectable contraceptives and assessing the quality of contraceptives.

VIII. Conclusion

63. The ACC Task Force on Basic Social Services for All was established to galvanize the United Nations system around priority goals emerging from the recent global conferences and to strengthen the system's follow-up mechanisms for delivering coordinated assistance at the country and regional levels. A number of factors contributed to the synergistic collaboration and coordination achieved by the Task Force:

(a) All Task Force member organizations and agencies committed themselves to participating collaboratively on key issues and substance without being limited to representing only their individual agency interests;

(b) That commitment was also reflected in the time and resources (both staff and funds) provided by the Task Force members to organizing meetings, conducting follow-up and preparing the end-products;

(c) The selection of lead agencies to head the working groups was based not only on their mandates but also on their ability to contribute to and complete the tasks;

(d) The formation of informal networks of Task Force colleagues who could relate to each other in quick, informal, non-bureaucratic ways, frequently using electronic communication and sometimes linking up in connection with other duty travel, created synergy and kept the process moving forward with a focus on results;

(e) Task Force objectives were clear and well-defined, and a specific time-frame was set in which to achieve them;

(f) A spirit of cooperation prevailed (for example, some meetings were held in Geneva instead of New York to facilitate participation of Europe-based members; also some meetings were held back-to-back to save time and money; additionally, at the request of the Canadian International Development Agency, the Task Force discussed and subsequently provided feedback to it on its draft policy paper on meeting basic human needs;

(g) The secretariat organized meetings, prepared and distributed reports, tracked the meeting of deadlines and facilitated coordination and follow-up among the Task Force members.

64. Factors that proved to be constraints included limitations of time and resources, which also caused some delays. Also, the assigned mandate of the Task Force was relatively broad, and in-depth coverage of all areas in the limited time allotted was not possible. The Task Force addressed this constraint by focusing on areas of comparative advantage and producing specific outputs that would assist programming at the country level. For example, the wall chart provides indicators and data that will enable countries to monitor and measure progress in achieving Conference goals in such key areas as population, primary health care, nutrition, basic education, drinking water and sanitation, and shelter. It should also be noted that the Task Force modality is generally effective for limited time-spans, and it may prove difficult to keep up the momentum beyond a certain time-period.

65. Lessons learned from the experience of the Task Force on Basic Social Services include the following: the mode of operation used by the Task Force — namely, working in a task-focused manner, frequently through informal networks, in addition to more established and formal inter-agency mechanisms, proved to be synergistic, quicker and more effective in producing results; clear and well-defined objectives and end-products allowed the Task Force to maintain a strategic focus and a specific timetable; Task Force working groups and member organizations demonstrated that they could work collaboratively in producing the agreed end-products in a timely manner and had no vested interests in establishing themselves as permanent structures; the Task Force experience, as well as that of the earlier Inter-Agency Task Force on Implementing the ICPD Programme of Action, demonstrates that within ACC, from time to time and as appropriate, the "task manager" approach can be used effectively for specific assignments. While this approach cannot replace established and permanent mechanisms which continue to have critical roles, it is important to recognize the value of the task force/task manager approach which can empower a wider group of actors and engender co-ownership through increased sharing of responsibilities and closer collaboration. Naturally, the competence, ability and track record in delivering results will determine the selection of task force leaders and focal points and shape the final outcome.

66. After distribution of its end-products to the field, the work programme of the Task Force will have been accomplished. The emphasis will be at the country level where the United Nations resident coordinator system will use the end-products to assist countries in implementing programmes focusing on achieving Conference goals, including the provision of basic social services for all. It is envisaged that the Turin Training Centre in Italy will develop training modules for field staff to facilitate and optimize use of the Task Force end-products. Theme groups and ad hoc task forces within the purview of the United Nations resident coordinator would be a useful modality for enhancing inter-agency coordination and collaboration at the country level. Many countries have already organized such groups, modelled on the ACC Task Forces. Non-governmental organizations and groups in civil society and the private sector should be involved in the country-level theme groups and task forces, and all end-products of the Task Force should be made available to them. The United Nations resident coordinator system can use this modality to strengthen and expand linkages with bilateral agencies, non-governmental organizations, the private sector and civil society and to draw on their areas of comparative advantage. The outputs of the Task Force should be linked to the common country assessments, country strategy notes and the United Nations development assistance framework. The regional commissions also have a key role to play in promoting and advocating use of the Task Force end-products. Regular information sharing and exchange, through the Internet and other such technologies, will facilitate better coordination and collaboration among key actors and all development partners at the country level and will also help to engender a sense of co-ownership.

Notes

[1] The members of the Task Force are: United Nations (Department of Economic and Social Affairs, Department of Humanitarian Affairs, Economic Commission for Africa, Economic Commission for Europe, Economic and Social Commission for Asia and the Pacific, Economic Commission for Latin America and the Caribbean, Economic and Social Commission for Western Asia), the Food and Agriculture Organization of the United Nations, the International Labour Organization, the International Monetary Fund, the Office of the United Nations High Commissioner for Refugees, the United Nations Centre for Human Settlements, the United Nations Children's Fund, the United Nations Development Fund for Women, the United Nations Development Programme, the United Nations Educational, Scientific and Cultural Organization, the United Nations Environment Programme, the United Nations Industrial Development Organization, the United Nations International Drug Control Programme, the United Nations Population Fund, the United Nations Relief and Works Agency for Palestine Refugees in the Near East, the World Bank, the World Food Programme and the World Health Organization.

[2] *Official Records of the Economic and Social Council, 1997, Supplement No. 4* (E/1997/24).

[3] See also "A revised approach for the allocation of UNFPA resources to country programmes" (DP/FPA/1996/15).

[4] See *Indicators for Assessing the Performance of Reproductive Health Programmes: A Discussion Paper* (New York, UNFPA, April 1997).

[5] *Indicators for Population and Reproductive Health Programmes* (New York, UNFPA, November 1997).

[6] See WHO document ICPHC/ALA/78.10.

[7] See A/CONF.165/14, chap. I.

[8] See E/ICEF/1992/22.

[9] Resolution 44/25, annex.

[10] See United Nations Population Fund, *Annual Report 1996* (New York, UNFPA, 1997).

[11] See the UNAIDS fact sheet *HIV/AIDS: The Global Pandemic* (Geneva, December 1997).

[12] Geneva, 1997.

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FOLLOW-UP ACTIONS TO THE RECOMMENDATIONS OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

ACTIVITIES CONDUCTED BY NON-GOVERNMENTAL ORGANIZATIONS AND INTERGOVERNMENTAL ORGANIZATIONS IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: THREE YEARS AFTER THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

Report of the Secretary-General

SUMMARY

The present report has been prepared by the United Nations Population Fund in accordance with the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, which was endorsed by the Economic and Social Council in its resolution 1995/55. Pursuant to the request of the Council in its resolution 1996/2, adopted on the recommendation of the Commission on Population and Development, the present report is a revised version of the report of the Secretary-General relating to the activities of the non-governmental sector in the area of reproductive rights and reproductive health submitted to the Commission at its twenty-ninth session.

The report, which reflects the responses received from 482 international, regional, national and grass-roots non-governmental organizations (NGOs) in 103 countries and four intergovernmental organizations, is intended to give a

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broad overview of the range of activities conducted by these organizations in the areas of sexual and reproductive health and rights. It assesses the strategies and approaches adopted by NGOs to implement the recommendations of the Programme of Action of the International Conference on Population and Development. It also provides an analysis of the difficulties and constraints encountered by NGOs in implementing sexual and reproductive health and rights programmes and services, in monitoring the implementation of the recommendations of the Conference and in working in partnership with Governments.

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I. INTRODUCTION

1. The International Conference on Population and Development, held at Cairo in 1994, was instrumental in articulating a response to a worldwide demand for improving quality of care and for integrating family planning into the broader context of sexual and reproductive health and rights. Governments of almost all countries of the world reached a consensus on the concept of sexual and reproductive health, clearly recognizing the rights of individuals to high quality reproductive health services. Non-governmental organizations (NGOs), both as participants and as part of national delegations, played a critical role in formulating the Programme of Action of the International Conference on Population and Development.[1] The Programme of Action identifies a critical role for NGOs in its implementation, in partnership with Governments and the private sector.

2. In accordance with the request of the Economic and Social Council in its resolution 1996/2, adopted on the recommendation of the Commission on Population and Development, the present report is a revised version of the report of the Secretary-General relating to the activities of the non-governmental sector in the area of reproductive rights and reproductive health that was submitted to the Commission at its twenty-ninth session.[2] The report summarizes the information gathered through a questionnaire sent to international and national NGOs and to intergovernmental organizations (IGOs) to assess their progress towards achieving the goals and objectives of the Programme of Action.

3. The findings included in the report are based on responses to a questionnaire completed by 482 national and international NGOs and IGOs; reviews of written reports and materials shared by respondent organizations; and interviews with some key NGOs involved in monitoring the implementation of the Programme of Action at the international level.

4. Section II describes the main characteristics of NGOs; section III refers to the mandate of the Programme of Action on the role of NGOs; section IV discusses the methodology used in preparing the report; section V provides an overview of the activities accomplished by NGOs in the area of sexual and reproductive health and rights; section VI discusses the role of NGOs in monitoring the implementation of agreements reached at the Conference; section VII focuses on collaboration between Governments and NGOs; section VIII analyses the limitations of the work of NGOs; section IX provides an overview of the activities of IGOs; and section X discusses the lessons learned from the involvement of NGOs three years after the Conference.

II. WHO ARE THE NGOS?

5. NGOs are organizations of civil society that are formally constituted, self-governing and non-profit and are characterized by some degree of voluntary involvement. They include special interest organizations; networks; service providers and public service contractors; funding, operational and advocacy NGOs (particularly women's NGOs); professional associations; community associations;

and paid membership organizations. NGOs exist at the international, regional, national and grass-roots levels.

6. In many countries, national and local NGOs concentrate efforts on the "supply side", delivering services or assisting Governments to increase the coverage of national programmes. Other NGOs concentrate on the "demand side" by helping different segments of the community articulate their concerns and preferences on such matters as quality of care, by influencing policy agendas and by mixing technical operational skills with communication, advocacy and networking skills. International NGOs participate in the development of global policies; in monitoring the implementation of the Programme of Action at the global level; in providing technical assistance to Governments of developing countries; and in conducting research studies.

7. Many NGOs have demonstrated an ability not only to serve segments of the community that are difficult to reach, such as adolescents or women living in poor communities, but also to provide high quality services, to work in inaccessible or sensitive areas and to test innovative approaches. In addition, they help in making the whole Conference implementation process more accountable, transparent and participatory. They not only fill gaps but also identify areas that require further attention.

III. THE PROGRAMME OF ACTION AND NGOS

8. The Programme of Action recognizes the need for establishing partnerships with NGOs for the implementation of the recommendations of the Conference. For instance, paragraph 15.6 of chapter XV of the Programme of Action (Partnership with the non-governmental sector) specifies that:

> "In recognition of the importance of effective partnership, non-governmental organizations are invited to foster coordination, cooperation and communication at the local, national, regional and international levels and with local and national governments, to reinforce their effectiveness as key participants in the implementation of population and development programmes and policies. The involvement of non-governmental organizations should be seen as complementary to the responsibility of Governments to provide full, safe and accessible reproductive health services, including family planning and sexual health services."

9. The Programme of Action also emphasizes the need to ensure that NGOs and their networks are able to maintain their autonomy and strengthen their capacity through regular dialogue and consultations, as well as through training.

IV. METHODOLOGY USED FOR COLLECTING INFORMATION ON NGOS AND IGOS

10. The methodology used for preparing the present report was a questionnaire sent to NGOs and IGOs, supplemented in many cases by their annual reports and other materials. Some direct interviews with selected NGOs were also carried out. The questionnaire for NGOs and IGOs was developed by topic area and

included the most significant aspects identified in the Programme of Action of the role of NGOs in the implementation of sexual and reproductive health and rights. In order to obtain a globally representative response, the questionnaire was sent to NGOs in all regions, at all levels – grass roots, national and international - and in different substantive areas, such as service delivery and advocacy.

11. The questionnaire, which was issued in English, French and Spanish, was sent to national and local NGOs through representatives of the United Nations Population Fund (UNFPA) who, in turn, were asked to suggest additional NGOs to include in the original list. It was sent to approximately 938 organizations worldwide, 920 NGOs and 18 IGOs, between July and August 1997. Of this total, 116 entries were received from the additional NGOs contacted by UNFPA field offices. From the total of 938 questionnaires sent, 482 were returned to UNFPA, representing a response rate of 51 per cent. The response by region (numbers and response rate) was distributed as follows: Africa, 131 (49 per cent); Asia and the Pacific, 142 (72 per cent); Arab States, 33 (27 per cent); Eastern European countries, 13 (48 per cent); Latin America and the Caribbean, 86 (51 per cent); developed countries in Western Europe, North America, Australia and New Zealand, 73 (53 per cent); and IGOs, 4 (22 per cent) (see table 1).

Table 1. Total number of NGO and IGO responses, by geographical region

	(1)	(2)	(3)	(4)	(5)	(6)
	Number of questionnaires sent to NGOs	Number of additional questionnaires sent by field offices	Total number of questionnaires sent to NGOs	Number of questionnaires received from NGOs	Percentage distribution	Rate of response (4)/(3)
Africa	223	45	268	131	27	49
Asia and the Pacific	160	36	196	142	29	72
Arab States	121	3	124	33	7	27
Eastern Europe	26	1	27	13	3	48
Latin America and the Caribbean	136	31	167	86	18	51
Developed countries	138	-	138	73	15	53
IGOs	18	-	18	4	1	22
Total	822	116	938	482	100	51

V. OVERVIEW OF ACTIVITIES DEVELOPED BY NGOS IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

12. There is a widespread sense among NGOs that the International Conference on Population and Development marked a turning point for them. Although many NGOs were already involved in the area of sexual and reproductive health long before the Conference was held, they recognize that the Conference served to legitimize them as genuine partners in the implementation of the Programme of Action. In many countries, as a result of the Conference, members of national NGOs have gained direct access to ministries and international agencies as never before, and they are now consulted widely on reproductive health efforts. At the same time, their role as watchdogs is also growing. Over the past three years, therefore, NGOs appear to have assumed an increasing role in the implementation of the Programme of Action. Some have expanded significantly in size, degree of influence and scope of work.

13. Due to their diversity, it is not possible to describe the average NGO. For the purpose of analysing their role in the implementation of the Programme of Action, they have been divided into advocacy and service NGOs at the international, regional, national and local levels. Regardless of this division, many NGOs working in the provision of services are also involved in advocacy activities. A large number of advocacy NGOs work in the area of reproductive rights - trying to raise public awareness, to mobilize support and to influence and participate in the development of policies. As for service NGOs, they participate in the delivery of services, training, the provision of technical assistance and research. Both types of NGOs appear to take part in monitoring activities related to the Conference.

A. Role of the Programme of Action

14. Because it represents a commitment to sexual and reproductive health and a platform for common action developed on a consensus basis, many NGOs reported that the Programme of Action has helped them to guide their own process of operationalizing sexual and reproductive health; to negotiate with Governments and other agencies; to monitor national programmes and activities; and to remind national authorities about their responsibilities and obligations.

15. NGOs have utilized the Programme of Action for a variety of purposes, including training; information, education and communication (IEC); advocacy; lobbying; and the development of projects and programmes. For some NGOs, such as PROFAMILIA in Nicaragua - a family planning organization - the Programme of Action represents a model for the reorientation of programmes towards providing reproductive health services. For many others, such as Marie Stopes International in Ethiopia, the recommendations endorsed by the Conference have renewed the enthusiasm of their pre-Conference commitment to sexual and reproductive health.

16. The Programme of Action has also served as a framework for protecting reproductive rights. For example in the Philippines, the Philippine Center for Investigative Journalism (PCIJ) - an advocacy NGO working in communications - used the Programme of Action as a platform to speak out for women's rights, with

the endorsement of the Government, when a governor in a province south of Manila ordered a ban on modern contraceptives. In India, NGOs have used the Programme of Action to advocate for a target-free approach to family planning.

17. In Denmark, the Programme of Action has been instrumental in guiding the reorganization of the Danish Family Planning Association. In addition to contraceptive services, it now offers pregnancy counselling, and counselling and testing for sexually transmitted diseases (STDs), among other services, to every clinic user. This has meant an improvement in meeting the needs of clients and an improvement in the quality of services provided.

18. In summary, the Programme of Action is used by the majority of NGOs. The document stands as a common tool that they share with Governments and international organizations. It is also a critical instrument that they can use to ensure that national authorities, IGOs and NGOs themselves keep the promises made at the Conference.

B. Advocacy activities developed by NGOs

19. Since the Conference, many NGOs have adopted ground-breaking advocacy strategies. They advocate in favour of the human rights basis for ensuring sexual and reproductive rights through the provision of information and by providing a wide range of services. NGOs have been active in reinforcing changes in policies and legislation, mobilizing support to ensure reproductive rights, and in raising public awareness relevant to sexual and reproductive health and rights.

20. Of the total 482 NGOs responding to the questionnaire, 247 (52 per cent of the respondents) reported undertaking advocacy activities for raising awareness on reproductive health issues and 193 (40 per cent of the respondents) reported undertaking advocacy activities to mobilize public support for reproductive rights and to ensure that they are respected. Most of these groups are women's NGOs. It is interesting to note that numerous NGOs report that they are now including advocacy activities to complement their service activities.

21. Role of NGOs in mobilizing public support for ensuring reproductive rights. Many NGOs are working to ensure that the reproductive rights of women and men are guaranteed in the context of human rights. They promote gender equality and equity, document violations, push for legal and procedural reforms and mobilize community support. The Center for Reproductive Law and Policy (CRLP) in New York is working to enhance global awareness of the existence and operation of laws and policies that affect the reproductive rights of women. It is preparing a series of reports that describe and analyse legal codes and cultural practices affecting women's reproductive choices in 51 countries around the world.

22. Many NGOs that focus on human and reproductive rights have formed alliances to promote their shared concerns. For example, Arrow, a network of NGOs in South-East Asia, has developed a health resource kit that includes a women-centred reproductive health framework; the perspectives of three countries on the issue; policies and programmes that could be used for effecting change; a

directory of resource materials; and tools that could be used to improve family planning and reproductive health programmes.

23. Participation of NGOs in the development of sexual and reproductive health policies and laws. According to the respondents, NGOs appear to be increasingly involved in the development of policies and laws in some countries. They often participate as advisers to specially created commissions that review national plans, discuss and elaborate policy changes and organize national consultations. They are also actively involved in lobbying to influence the agenda of lawmakers. For example in Argentina, NGOs have been instrumental in creating a favourable environment to draft a reproductive health law currently in the process of approval.

24. Role of NGOs in raising public awareness for sexual and reproductive health. Advocating for the recommendations of the Programme of Action means striving to make sexual and reproductive health services available and accessible to all, addressing the needs of adolescents, involving men in programmes, empowering women and promoting gender equality. According to responses to the questionnaire, NGOs are actively involved in campaigns promoting the use of services that will address these needs. In India, the organization Voices has developed a reproductive health information kit. It was designed for health workers to reach out to and empower women and men of the community to take decisions regarding their reproductive needs.

25. International NGOs play a critical role in developing the institutional capacity of many national advocacy NGOs. For example, the International Women's Health Coalition provides technical and financial assistance to help national NGOs get started and to assist those that are already established to grow and effect policy change in their own countries.

26. Also at the international level, advocacy NGOs are actively involved in influencing global communication networks and national media to raise awareness of reproductive health issues. They also try to lobby their own Governments, which, in turn, may convince other national Governments to implement reproductive health in their own countries. The advocacy NGOs are also involved in monitoring the implementation of the recommendations of the Conference and in trying to influence the agenda of donors and their own Governments to increase funding for NGOs working in reproductive health. These NGOs have been instrumental in the creation of NGO networks in many regions of the world that try to raise awareness on specific issues related to women's health.

C. Role of NGOs in the provision of quality sexual and reproductive health services

27. Although there are still some NGOs working on traditional population-based and stand-alone family planning programmes, many of the NGO respondents reported that the Programme of Action had greatly influenced them in integrating family planning into other reproductive health services. Almost one third of the NGO respondents from developing countries provide all the following services: family planning; maternal health; and prevention of reproductive tract

infections and STDs, including human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

28. The Programme of Action identified a series of key issues to be included in the provision of services to meet the reproductive health needs of the population. A broad analysis of the work conducted by service NGOs indicates that quality of care and adolescents are the areas that attract particular attention. An important number of national NGOs indicated that they tend to provide selected services to marginalized populations because of the unavailability of public services in the areas where these people live. In addition, many NGOs reported addressing sensitive or controversial issues such as providing services to battered women and to adolescents.

D. Quality of care

29. The Programme of Action stressed the need to improve the quality of care of reproductive health programmes as an effective way to address existing unmet demands for reproductive health information and services. Table 2 shows that across all regions (with Latin America having the highest percentage), the majority of NGO respondents - including both those that do and those that do not provide services - are committed to the "quality of care" approach.

Table 2. Total number and percentage of NGOs working in quality of care activities

	Total number of NGOs	Total number and percentage of NGOs committed to the quality of care approach
Africa	131	55 (42%)
Asia	115	50 (43%)
Latin America	86	54 (63%)
Arab States	33	17 (52%)
Eastern Europe	12	5 (42%)
Total	377	181 (40%)

30. Among NGOs, there appears to be a common general understanding of what quality of care is. Many service NGOs are working to promote referral systems and strengthen linkages with other reproductive health services, to develop tools for understanding user needs and to expand contraceptive choices in both their own and national programmes.

31. Parivar Seva Sanstha is an Indian NGO that has been working in the provision of comprehensive reproductive health services for many years. Since the beginning it has worked to stand as a model for quality of care in family

planning, maternal health, reproductive tract infections, abortion and programmes for adolescents. Based on its experience, it is collaborating with the Government to improve the quality of programmes. In China, the Institute of Population Research at Beijing University reported that its project to introduce new contraceptives with informed choice and to improve services has received a great deal of attention from international organizations and donor countries.

32. Numerous advocacy NGOs are training providers in the concept of gender equality and in the need to provide services that respond to users' reproductive intentions. They have also monitored human rights abuses in family planning programmes and demanded respect for the right of people to freely select their contraceptive choice. In Mexico, for example, the Red de Salud Reproductiva del Distrito Federal (Reproductive Health Network of Mexico City) organized a public tribunal to denounce cases of abuse in reproductive health services. This resulted in the commitment of programme managers to improve the quality of services provided, including amelioration of the way women are treated in those services.

E. Working with groups that have special needs

1. Adolescents

33. Until recently, adolescents were often largely neglected in reproductive health programmes. One of the probable reasons for this is the unfounded fear that providing information and services encourages sexual activity. As a result, unmarried adolescents have been denied access to services in many countries by law or policy. Since the Conference, NGOs have increasingly addressed the reproductive health needs of adolescents. Many NGOs appear to have included adolescents in the development of programmes. Others have expanded the scope of their work, taking a more comprehensive approach that addresses a variety of adolescent needs within the context of a comprehensive approach to health. Table 3 shows the number of NGOs working with adolescents by region and sex.

34. The use of the media has proved to be an effective strategy in targeting adolescents. In Nigeria, a local NGO, YouthAid, uses private television stations to provide counselling to adolescents. It is the first of its kind devoted solely to adolescent reproductive health. Also in Nigeria, ADON designed a parent-child communications programme that trains parents as educators in sexuality. In the Philippines, multimedia service centres for youth have been established in three cities with media services that include a cable television music programme, television movies and school tours.

Table 3. Number of NGOs working with adolescents, by region and sex

	Total number of NGOs	Number of NGOs working with adolescent females	Percentage of NGOs working with adolescent females	Number of NGOs working with adolescent males	Percentage of NGOs working with adolescent males
Africa	131	81	62	68	52
Asia	142	45	32	32	23
Latin America	86	44	51	32	37
Arab States	33	19	58	17	52
Eastern Europe	13	9	69	9	69
Developed countries	73	19	26	19	26

2. Males

35. The reproductive health needs of men and their influence on women's reproductive health decisions have often been ignored by family planning services in the past. An analysis of the responses to the questionnaire show that many of the NGOs that state that they work with males in fact work with adolescent males. The number of NGOs working with adult males appears to be very small. Most of the activities of NGOs working with males are implemented by international NGOs. Johns Hopkins University has developed a project focusing on men's participation in family planning and reproductive health that was launched at a conference of policy makers and programme managers from sub-Saharan Africa in 1997. The project uses sports, particularly soccer, as a vehicle for providing reproductive health messages for males.

36. NGOs are just beginning to work with males. Working with men on sexuality and gender roles and in the development of services tailored to their needs appear to be the issues around which NGOs are developing their work.

3. Refugees

37. The need for the provision of reproductive health care services in refugee camps has been widely discussed since the Conference. More and more NGOs are involved in the provision of such services.

38. A high proportion of NGO respondents from the Arab and Eastern Europe regions have been addressing the reproductive health needs of both female and male refugees. In Africa, international NGOs such as Médecins du monde, the International Red Cross and Marie Stopes International are providing services in refugee camps and are part of the Reproductive Health for Refugees Consortium of NGOs. This is a network of NGOs that are working together in the development of tools to rapidly implement reproductive health services in emergency situations.

4. Women: female genital mutilation and violence against women

39. In countries where female genital mutilation is widespread, numerous NGOs are working to eradicate such practices. Female genital mutilation has been identified as a risk for reproductive health and a violation of women's human rights. The Population Council has assisted the Government of Mali in developing a research plan, intervention and policy to eventually eradicate female genital mutilation. In Burkina Faso, the Population Council helped an advocacy NGO to organize a regional conference to design ways to influence policies for the eradication of female genital mutilation.

40. NGOs are clearly very active in providing legal and clinical services for women suffering from abuse by their partners. A large proportion of advocacy NGOs are working in this area. Flora Tristan, an NGO with almost 20 years of experience in the field in Peru, is working to address this neglected and universal issue by training police officers and by providing legal support to victims.

F. Training activities

41. Training is one way in which NGOs have been able to make their activities more sustainable over time. Through training activities, experience accumulated in their own work is very often transferred to government staff and/or to other national and local NGOs. Approximately 50 per cent of NGO respondents offer training as a way of transferring resources. Advocacy NGOs provide training to programme managers, community leaders and the community in general on gender issues and on the principles of reproductive health. Service NGOs are often involved in training providers, counsellors and programme managers on the different aspects of service provision. For example, the Women's Health Coalition in Bangladesh trains paramedics and doctors in the provision of sexual and reproductive health care. In addition, they have an exchange programme through which they train providers from other national and foreign NGOs.

42. International NGOs also provide assistance in training. For example, the International Training Programme in Health (INTRAH), an international NGO based in the United States of America, trains health providers in all components of reproductive health, mainly family planning, the prevention and control of STDs and maternal health care, in Benin, Ghana, Guinea, Morocco and Togo. It also assists Governments in the development of training curricula and by providing training equipment.

G. Participation of NGOs in research activities

43. The new approach to reproductive health following the International Conference on Population and Development has posed enormous challenges in the area of research. Important research issues include the needs and opinions of clients; the needs of women and men concerning sexuality and reproduction at different stages of their lives; and the gender perspective. New methods of research such as rapid assessment procedures (RAP) are also used by many NGOs. For example, Reprosalud is a project developed by the NGO Manuela Ramos in Peru, with substantial financial support from the United States Agency for International Development (USAID) that has the objective of increasing the demand for reproductive health services in rural areas of Peru. The project consists of three modules, including reproductive health, income-generating activities and advocacy, and the whole process begins with the development of a community self-assessment of needs using RAP.

44. International NGOs, such as the Population Reference Bureau, conduct national-scale surveys - demographic and health surveys (DHS) - that have been used to evaluate family planning programmes. At present, many research NGOs are incorporating other aspects of reproductive health into such surveys. They are also contributing to the improvement of national databases, which in turn provide information on important aspects of reproductive health. For example, the Centre d'études et de recherches sur les populations africaines et asiatiques in Paris has designed a methodology called "multidisciplinary monographs" that contributes to providing information at the national level, including local and regional multidisciplinary data, that sample surveys such as DHS cannot provide. At the same time, this methodology allows in-depth investigations of attitudes and behaviours with respect to reproductive health issues. The methodology has been successfully applied in Burundi, Cameroon, Mali, Mauritius and Senegal.

VI. ROLE OF NGOS IN MONITORING THE IMPLEMENTATION OF THE PROGRAMME OF ACTION

45. Monitoring progress in the implementation of the Programme of Action has required the creation of new mechanisms of follow-up, the revitalization of existing structures and the strengthening of participatory processes. In many countries, particularly developed countries, there are institutional mechanisms that can be used to follow up on the implementation of the Programme of Action. However, in the developing world, the creation of follow-up mechanisms has taken longer. This is in part owing to the lack of available instruments to measure progress - mainly indicators - as well as the absence of baseline studies to document the current reproductive health situation in each country against which progress can be assessed.

46. Many Latin American countries report the creation of commissions with NGO representation to follow up on the agreements reached at the Conference. However, some national commissions have not taken a very pro-active approach. Peru has recently created a Tripartite Commission with the participation of the Government, NGOs and UNFPA. Mexico has created the Interinstitutional Group in

Reproductive Health. In Chile, NGOs are working with the Government to create a National Commission on Population and Development.

47. Many of the NGOs participating in these commissions are members of the Latin American and Caribbean Network on Women's Health. The Network has identified six thematic issues to monitor in each country where the NGOs work, including sexuality and the reproductive health of adolescents, quality of care, management of unsafe abortion, male involvement and the participation of women in decision-making. Qualitative and quantitative indicators have been elaborated for each of those issues and will be used to assess the reproductive health situation in each country.

48. USAID issued a report in 1996 entitled "Reproductive health programmes supported by USAID: a progress report on implementing the Cairo Programme of Action" that summarizes its initiatives. Although the report was an official one, NGOs concerned with USAID work were invited to provide comments and enquiries on that work. In the Netherlands, the World Population Foundation, through its Post-Cairo steering committee, is monitoring the extent to which the Government lives up to its Conference commitment to devote approximately 4 per cent of the budget of the Ministry of Development and Cooperation to sexual and reproductive health activities.

49. In Africa, the majority of NGOs have reported that there are mechanisms to monitor the implementation of the Programme of Action. But almost all reported that these mechanisms are the responsibility of Governments. The East African Reproductive Health Network in Uganda, Kenya and the United Republic of Tanzania is recommending the inclusion of NGOs in monitoring activities. In Nigeria, the Social Sciences and Reproductive Health Research Network plans to gather information that will eventually help to evaluate activities in the country. Even though a majority of NGOs mentioned specific monitoring mechanisms, there does not appear to exist a coordinated or consistent approach to monitoring responsibilities between government agencies and NGOs.

50. At the international and regional levels there are several monitoring experiences including the initiative coordinated by WEDO (Women in Development), HERA, coordinated by the International Women's Health Coalition, Arrow in the Asia and Pacific region and the Latin American Women's Health Coalition initiative. WEDO has published a document entitled "One year after Cairo", which is a comprehensive report on the national implementation of the Programme of Action.

51. In sum, a number of NGOs have been invited to participate in a number of newly created mechanisms in some countries to follow up on the implementation of the Conference recommendations, although it appears that not all these mechanisms are as yet operative.

VII. PARTNERSHIP OF NGOS WITH GOVERNMENTS

52. By subscribing to the Programme of Action, Governments and NGOs have begun to share common objectives and tools as well as a commitment to work together for its implementation. Numerous NGOs recognize that as a result of the

Conference they legitimately participate in the development of national policies and programmes.

53. An analysis of the responses to the questionnaire indicates that in those countries in which partnerships between NGOs and Governments are well established and channels of interaction are in place, implementation of the Programme of Action appears more articulated. A good working relationship between Governments and NGOs is conceivable only when both parties share common objectives. The responses to the questionnaire show that where the national commitment to reproductive health is not strong, NGOs feel frustrated in their dialogue and collaboration with Governments.

54. The nature of collaboration between Governments and NGOs varies from country to country. At the national level, NGOs collaborate with Governments in various ways - for example, in the implementation of projects; in policy making (serving on committees, assisting with public consultations); as links to communities; in training; by subcontracting services; and by providing subsidies in the procurement of contraceptives. In those areas where the decentralization process has begun (as is the trend in most regions of the world), NGOs are collaborating with local governments on specific projects, providing services and participating in local health committees, as has been the case in Brazil. At the international level, most NGOs tend to collaborate with Governments and national NGOs by providing training and technical assistance.

55. There have been several cases of successful collaboration between Governments and NGOs. In Bangladesh, for example, NGOs are grouped in a consortium and the Government works closely with them by subcontracting their services. In Mozambique, NGOs are in a constant process of consultation with the Government, providing training and participating in the development of projects.

56. Overall, where there is political commitment on the part of Governments to the principles of sexual and reproductive health, there seems to be positive progress in the collaboration between Governments and NGOs.

VIII. LIMITATIONS ON THE WORK OF NGOS

57. In spite of their intensive and impressive work, NGOs face many obstacles. Some limitations are intrinsic to the implementation of the Conference recommendations themselves and touch all actors at whatever level they work. For example, some NGOs report that they experience difficulties in working with some religious groups or in areas where cultural beliefs are strong - for example, where female genital mutilation is considered an important cultural tradition. There are also limitations related to the lack of appropriate technology to work in reproductive health in such areas as the prevention and management of STDs and the empowerment of women. Other obstacles are related to the work of NGOs as organizations. These include their dependence on external funding; the problems of growth as grass-roots NGOs take on national-level functions; and tensions in collaborating with Governments.

58. Funding is a major constraint for the majority of NGOs responding to the questionnaire. This is in part due to the increased number and competence of NGOs for the diminishing amount of existing funds and the incapacity of many to develop strategies for securing long-term funding. In fact, a major question about many NGOs is their sustainability. In many instances, an NGO may disappear following the withdrawal of support from the Government or donors or the departure of a charismatic leader who was effective in raising funds. In addition, many NGOs report that the funding policies of donors do not provide institutional support, which makes it difficult for them to develop long-term strategies for their development.

59. For those national NGOs that collaborate with Governments, this process has created a new dilemma. Many NGOs have recognized that collaboration may have some costs. There seems to be some tension between collaboration with Governments and the traditional watch-dog role of NGOs. Some NGOs reported that they felt that a greater degree of financial autonomy could help resolve this issue. However, one of the most important challenges for these NGOs in the post-Cairo era is the need to think more strategically about their role as partners of Governments and as representatives of special groups that have specific demands. Consideration of the proper role of an NGO that collaborates with the Government and at the same time tries to preserve its autonomy is a question that is often missing from the agenda of many NGOs. Strategic planning is a key issue for many NGOs. However, funds available for this are also limited.

60. For NGOs working in the provision of services, replicability is a major problem. Because of the particular nature of management and resource allocation, most NGO efforts remain unreplicable. However, some elements of NGO programmes have been successfully transferred to public sector programmes. NGOs also reported that lack of human resources and of opportunities for training are serious limitations to their work.

61. In sum, three years after the Conference, there appear to be new and old constraints in the work of NGOs. For some NGOs, resolution of the problems will very much depend on their ability to think strategically and on the willingness of donors and national programmes to encourage the sustainability of NGOs.

IX. INTERGOVERNMENTAL ORGANIZATIONS

62. Only two of the four IGOs that responded to the questionnaire conduct activities related to the implementation of the Programme of Action. They are the Fund for International Development of the Organization of Petroleum Exporting Countries (OPEC) and the Organization of African Unity (OAU).

63. The OPEC Fund is an intergovernmental development aid agency that provides financial assistance to developing countries in support of their social and economic development efforts. It often collaborates with reproductive health programmes but on a small scale. It has recently supported a project in Guatemala on maternal health and a project in Malaysia on training.

64. OAU is a regional organization of the African countries whose main goal is to promote cooperation among African States in the economic, social, cultural and educational fields. OAU adopted a resolution in 1995 requesting member States to make policy, institutional and financial arrangements for the implementation of the Programme of Action. Since then, OAU has organized numerous seminars, workshops and conferences for different target groups, such as the diplomatic community in Addis Ababa. In addition, a Steering Committee of African and Middle East Parliamentarians was organized to encourage and promote the formation of national committees of parliamentarians on population and development. Study tours to promote population issues will soon be implemented under this programme. The objectives are to seek areas of collaboration and exchange between Governments and NGOs on population issues.

X. CONCLUSIONS

65. A total of 480 local, national, regional and international NGOs have reported on progress and limitations in implementing the Programme of Action. Their work is complex and diverse, and there is no doubt that they will continue to make enormous efforts to advance the implementation of the Programme of Action.

66. Advocacy NGOs at the international and national levels are successfully placing sexual and reproductive health within the context of human rights and gender equality and are participating actively in monitoring the implementation of the Programme of Action.

67. Service NGOs have demonstrated clear progress in implementing the Programme of Action. Although it is true that some were applying the sexual and reproductive health approach long before the Conference was held, almost 54 per cent of the respondents reported that they are now providing reproductive health services in addition to family planning. Many NGOs that do not provide reproductive health services are referring users to those services. Almost all reproductive health components are being incorporated into programmes. Quality of care and adolescents are central areas in the work of NGOs. However, much remains to be done in the area of male involvement.

68. Increasingly, national NGOs are collaborating with Governments. Whatever the status of collaborative activities in each country, it is almost unthinkable now for Governments and international agencies to propose a reproductive health activity that does not include NGOs. International NGOs play a pivotal role in providing technical assistance and securing funds for national NGOs and in creating an international environment supportive of the work of NGOs throughout the world.

69. The number of responses received for this monitoring exercise is an indication that NGOs continue to be pro-active and are very enthusiastic about the recommendations of the Conference and their commitment to its operationalization. Through their responses, it is also clear that international and national support continue to be critical to the pivotal work they perform.

Notes

[1] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[2] Official Records of the Economic and Social Council, 1996, Supplement No. 5 (E/1996/25), para. 3.

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Flows of financial resources for population activities

Report of the Secretary-General

Summary

The present report responds to a request at the twenty-eighth session of the Commission on Population and Development for an annual report on the flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development (ICPD). The report has been prepared in accordance with General Assembly resolutions 49/128 and 50/124, in which the Assembly requested the preparation of periodic reports on the flow of financial resources for assisting in the implementation of the Programme of Action. The report also responds to suggestions made at the twenty-ninth session of the Commission on the need for comprehensive reporting of financial flows.

Preliminary estimates for resource flows in 1996 indicate that more than $1.8 billion of international assistance was expended on population activities for the implementation of the Programme of Action, a slight decrease compared to 1995. Domestic resource flows in 1996 are estimated at about $8 billion (by Governments, non-governmental organizations and private sources), giving a preliminary global total for population-related expenditures and allocations in 1996 of almost $10 billion.

Donor support in 1996 for ICPD implementation presents a mixed picture: several donor countries have shown increased commitment, while for other donors international assistance either stagnated or declined in 1996. Nevertheless, overall many donor countries have given increased priority to the ICPD goals in terms of the share of total official development assistance devoted to population. Early indications for 1997 are that unfavourable exchange rate movements may further depress international assistance measured in dollar terms in 1997.

* E/CN.9/1998/1.

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The preliminary estimate of $8 billion raised domestically for population includes the sizable allocations of a few large developing countries that give population programmes high priority. In contrast, most countries in sub-Saharan Africa, as well as some developing countries in other regions, have been able to mobilize only a small part of the financial resources that will be required for them to reach ICPD goals.

The present report also describes how information on both international and domestic flows is being expanded and systematically organized through a cooperative agreement between the United Nations Population Fund and an international non-governmental research institution. That collaboration has created a resource-flow database which will progressively become a valuable tool for monitoring the global financial flow aspect of the implementation of the Programme of Action.

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I. Introduction

1. The present report has been prepared by the United Nations Population Fund (UNFPA) in response to a request at the twenty-eighth session of the Commission on Population and Development[1] for an annual report on the flow of financial resources and funding mechanisms for implementing the Programme of Action of the International Conference on Population and Development (ICPD)[2]. The report, which is part of the work programme of the Commission on Population and Development, is also pursuant to General Assembly resolutions 49/128 and 50/124, in which the Assembly called for the preparation of periodic reports on the flow of financial resources for assisting in the implementation of the Programme of Action.

2. The present report reviews (a) the flow of financial resources in external assistance for population activities for 1995, and provisionally for 1996 and 1997, when available, and (b) domestic flows for 1996. The report is based on data gathered through a new collaborative project between UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI), an internationally recognized population research non-governmental organization. Because of the early cut-off date for the present report, data are incomplete, particularly for developing countries, and the results presented for 1996 are therefore preliminary.

3. The specific financial flows that are analysed in the present report are the resource flows — both international and domestic — allocated to the ICPD "costed population package" (see para. 13.14 of the Programme of Action), which consists of four main components: family planning services; basic reproductive health services; sexually transmitted diseases (STD)/human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) prevention activities; and basic research, data and population and development policy analysis. It was estimated in the Programme of Action that that package would cost about US$ 17 billion annually by the year 2000. Other important ICPD goals, such as universal basic education, primary health care and child survival, were not specifically costed in the Programme of Action and are not dealt with here. It was tentatively estimated that up to two thirds of the costed population package would be met by the countries themselves, with the remaining one third ($5.7 billion) to come from external assistance.

II. External assistance for population

4. During the period 1985 to 1995, international financial resource flows followed a generally increasing trend. A significant increase of 25 per cent was recorded between 1993 and 1994, reflecting the results of the ICPD process and the intentions of many Governments and organizations to increase their commitments to financial assistance for population programme activities. International population assistance increased by 24 per cent in 1995, reaching a level of just over $2 billion, of which developed countries contributed almost $1.4 billion, multilateral organizations and agencies (other than UNFPA) provided $111 million, private sources accounted for $85 million, and development banks (chiefly the World Bank) provided $466 in the form of multi-year loans.

5. Preliminary assessments based on responses to questionnaires on 1996 resource flows indicate that overall international assistance for population declined somewhat from 1995 levels (see fig. I). However, to date 1996 data are preliminary and still subject to change; in particular, 1996 data for some donor countries are estimates, not final figures, due to delays in reporting.[3,4] If any new information becomes available, the Commission will be updated informally.

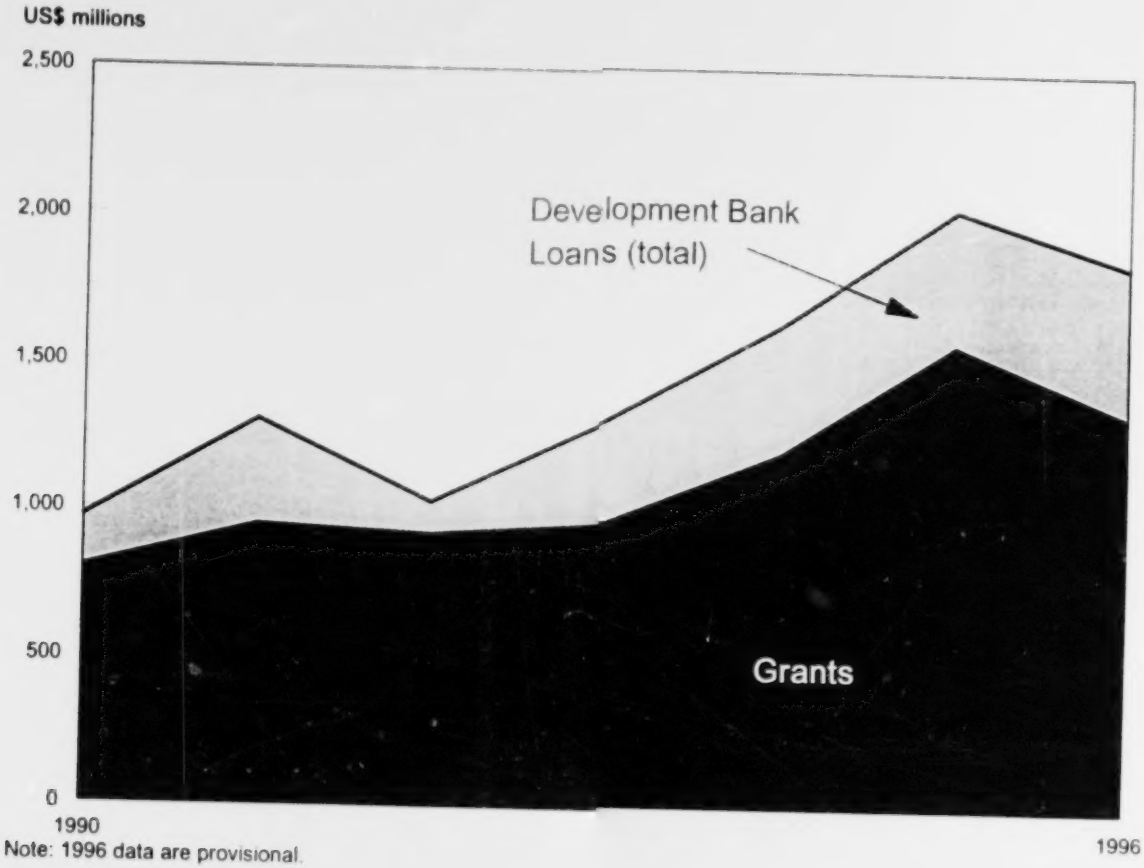
6. Total external assistance in 1996 is estimated at about $1.8 billion, a 9 per cent decline over the 1995 total; of that 1996 total, donor countries directly contributed about $1.2 billion and development banks $518 million, while private foundations increased their assistance in 1996 to $140 million.

A. Trends in donor country assistance

7. Direct grants from donor countries comprise the largest percentage of total international population assistance. Bilateral assistance increased from $669 million in 1990 to almost $1.4 billion in 1995. Direct grants from donor countries increased by 40 per cent in 1995 over the 1994 total of $977 million.

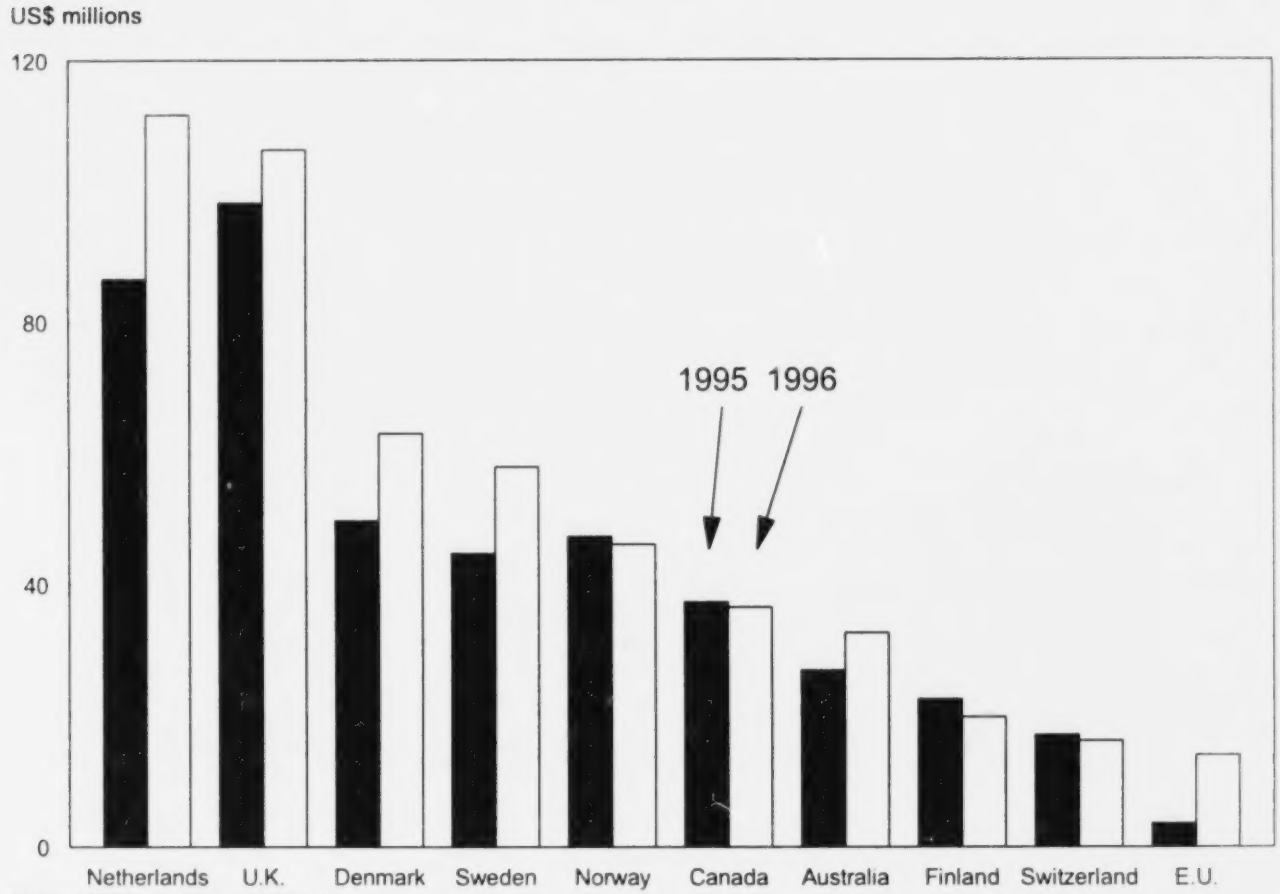
8. Preliminary indications point to a small decrease in primary funds of donor countries in 1996 in United States dollar terms, even though several countries either increased spending on population in 1996 or at least maintained 1995 levels (see fig. II). At least six countries (including the European Union) increased their 1996 funding over the previous year, while seven decreased their assistance. The largest absolute increases in population assistance came

Figure I
Trends in international population assistance, 1990-1996



Note: 1996 data are provisional.

Figure II
Bilateral population assistance, 1995 and 1996, selected countries



Note: 1996 data are provisional.

from the Netherlands, Sweden, Denmark, the European Union, the United Kingdom of Great Britain and Northern Ireland and Australia. The largest relative increases over 1995 figures (in percentage terms) were posted by the European Union, Sweden, the Netherlands and Denmark (see sect. IV below for more information on new European Union initiatives).

9. Unfortunately, assistance from some other donor countries declined in 1996. The largest decline was in assistance from the United States of America, whose provisional (and incomplete) total for 1996 is $463 million, a decrease of more than $200 million from 1995.[4] Nonetheless, in 1996 the United States retained its first-place position in absolute terms and in terms of the percentage of official development assistance (ODA) earmarked for population (5.1 per cent). External assistance from Austria, Finland, Ireland, Italy and Canada also declined from 1995 to 1996.[5]

Exchange rates

10. Since the standard currency for tracking global resource flows is the United States dollar, the effect of currency fluctuations and unfavourable trends in exchange rates has been examined. Figure III shows the seven donor countries which experienced the largest exchange-rate swings over the period 1994-1996; other countries, not shown, experienced smaller swings of less than two percentage points. However, as can be seen, currency fluctuations cannot account for the overall decrease in assistance. Only two countries (Japan and Switzerland) saw their currencies weaken significantly against the dollar, decreases that were more than offset by several other currencies which appreciated against the dollar over the same period. Overall, if 1994 (or 1995) exchange rates had prevailed in 1996, donor assistance for population would have been slightly *lower* in 1996 than it in fact was.

Comparison to official development assistance

11. Primary funds of donor countries for population assistance as a percentage of official development assistance followed an upward trend during the period 1990 to 1995, increasing from 1.21 per cent in 1990 to 2.32 per cent in 1995. That upward trend was reversed in 1996, however, when the primary funds of donor countries for population assistance as a percentage of ODA decreased to 2.10 per cent. The decrease can be partly explained by the exclusion in 1996 of expenditures on infant and child care, but it is mainly due to the large decrease in assistance from the United States.

12. Individual countries varied greatly in the proportion of ODA contributed for population assistance in 1996. Despite the overall decrease in assistance for population, an encouraging trend noticeable in 1996 data is the growing group of donor countries which earmark an important part of their ODA for population activities. Whereas in 1995 only five donor countries devoted 3 per cent or more of ODA for population, in 1996 eight countries reached that plateau — the United States, Finland, Denmark, Norway, Netherlands, the United Kingdom, Australia and Sweden — indicating a welcome shift to according higher priority to population activities despite an overall stagnation in ODA contributions.

Comparison to gross national product

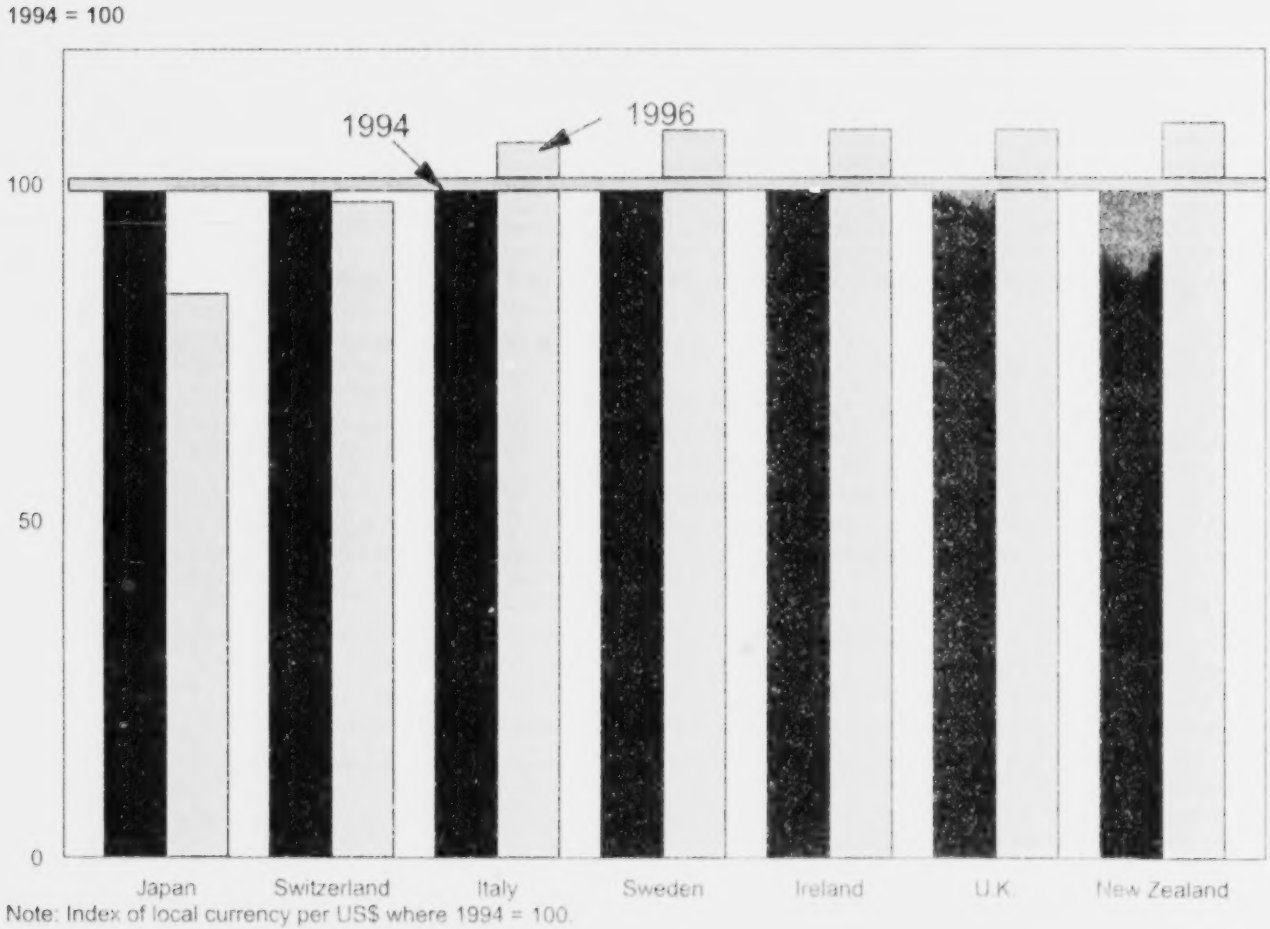
13. A country's commitment to population assistance can also be measured in relation to its gross national product (GNP). In 1990, donor countries contributed, on average, $43 for each million dollars of GNP to population assistance. That figure has fluctuated in the past several years, increasing to $62 in 1995 but decreasing substantially in 1996, when donor countries contributed only $53 per million dollars of GNP to population assistance. Again, most of that decline can be attributed to the (provisional) decline in population aid from the United States from 1995 to 1996.

14. Several countries provided population assistance well above the average in terms of GNP. Denmark topped the list in 1996 for the first time, by contributing $370 for every million dollars of its GNP. Norway, the Netherlands, Sweden and Finland also provided high rates of population aid relative to their GNPs.

Donor contributions to UNFPA

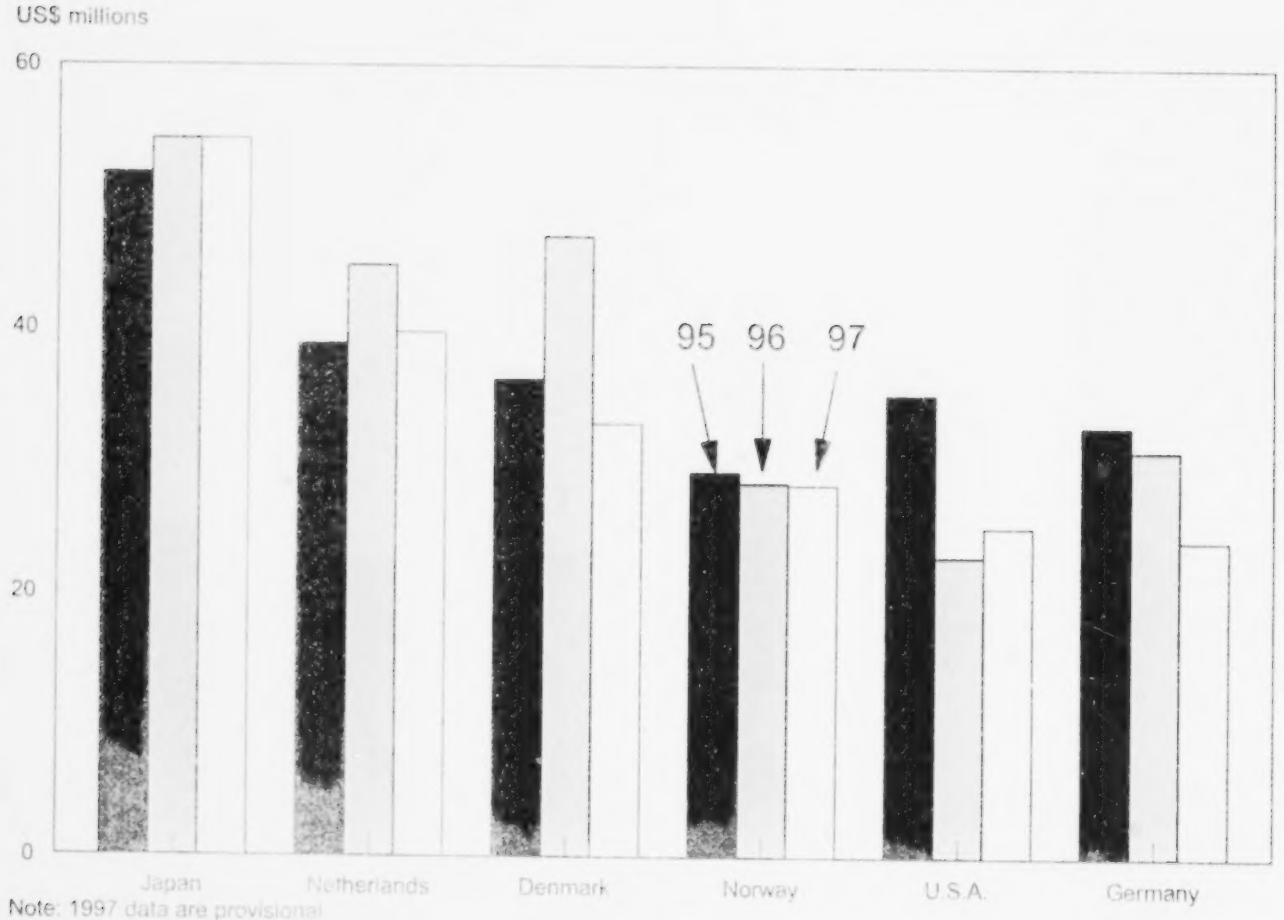
15. Donor countries also provide substantial contributions to population assistance through the multilateral channel. The largest multilateral source of population assistance is UNFPA. Figures IVa and IVb show the contributions of 12 Organisation for Economic Cooperation and Development (OECD)/Development Assistance Committee (DAC) donor countries to UNFPA core resources between 1995 and 1997 in dollar terms.[6] Of the countries shown, the largest increase in dollar terms from 1996 to 1997, $2.25 million, came from the United States. Several other donors increased contributions to UNFPA between 1996 and 1997 in both their own currency and dollar terms: Ireland, New Zealand, Luxembourg and Portugal. A number of other donor countries, including Finland, the Netherlands, Norway and Switzerland, increased contributions in 1997 over 1996 when

Figure III
Exchange rate fluctuations, 1994 and 1996



Note: Index of local currency per US$ where 1994 = 100.

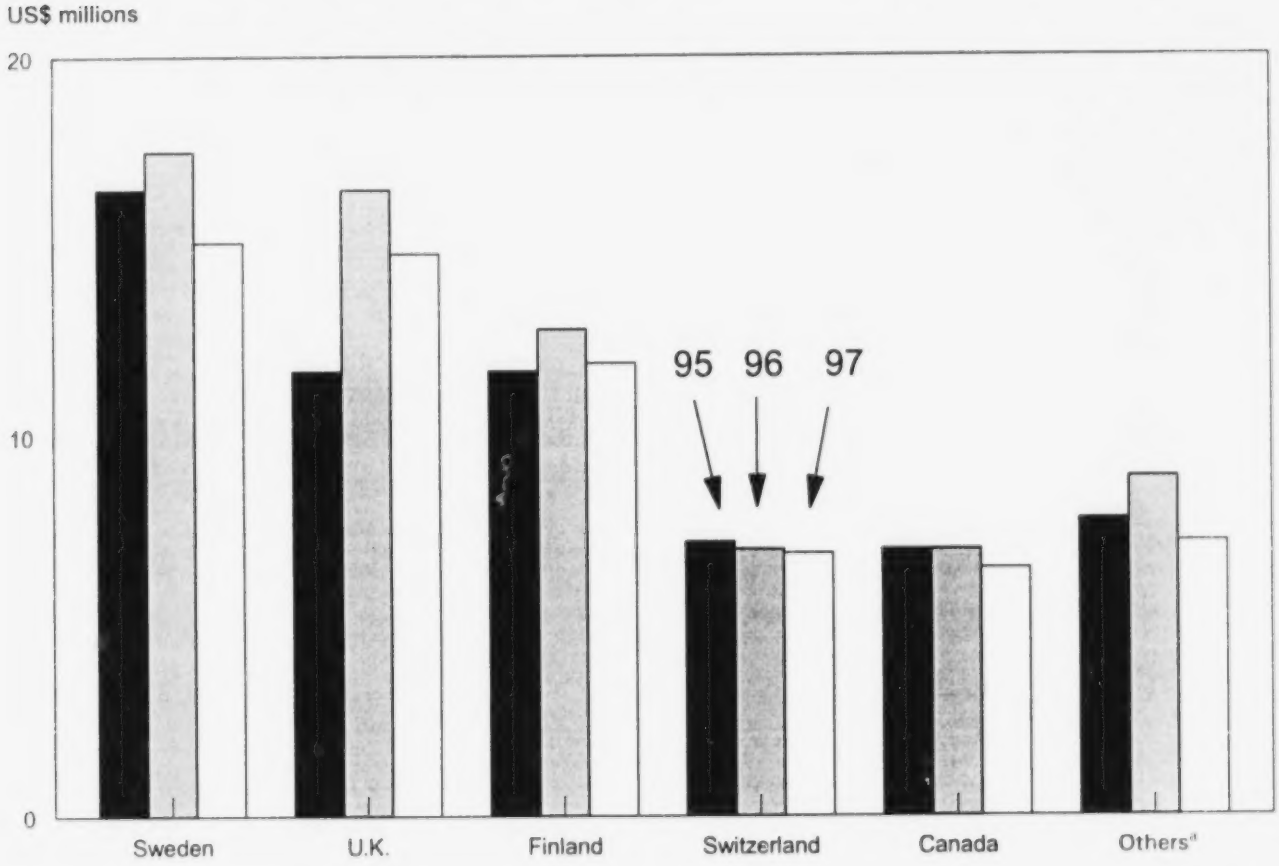
Figure IVa
Donor assistance to UNFPA core resources, 1995-1997
(Scale: 0-60 million dollars)



Note: 1997 data are provisional.

Figure IVb
Donor assistance to UNFPA core resources, 1995-1997

(Scale: 0-20 million dollars)



Note: 1997 data are provisional.

[a] Australia, Austria, Belgium, France, Ireland, Italy, Luxembourg, New Zealand, Portugal.

measured in their own currencies, but because of shifts in exchange rates at the time they were recorded as decreases in dollar terms. Sweden and France maintained their 1997 contributions at the same level as 1996, but again these decreased in dollar terms because of fluctuating exchange rates.

16. UNFPA income data available for 1997 suggest that exchange rates will have a depressing effect on donor aid for population in 1997 in dollar terms. A calculation was made for 16 DAC countries who contribute to UNFPA in their own currencies. In terms of United States dollars, those 16 countries together gave UNFPA $220 million in 1996 and $187 million in 1997 — a total decrease of $33 million. However, if the exchange rates prevailing when the 1996 contributions were made had remained unchanged in 1997, the 1997 total for those 16 countries would have been $209 million. Thus, funds for UNFPA-supported programmes in 1997 would have been $22 million higher, 12 per cent more than the actual dollar total. Figure IVc shows how 1996 and 1997 donor contributions to UNFPA in local currencies rose or declined relative to 1995 contributions (which are standardized to equal 100 and shown as a vertical line in the figure).

17. Despite tight budgetary constraints and in some cases difficult economic climates, Denmark, the Netherlands, Switzerland, Finland, Sweden, the United Kingdom, Canada and Germany made substantial contributions to UNFPA in 1997. Japan maintained its position as top donor to UNFPA, with a net contribution of over $54 million.

B. Trends in multilateral grant assistance

18. A number of United Nations organizations and bodies that engage in population-related or reproductive health activities are also sources of funds for multilateral population assistance, including the International Labour Organization, the United Nations Children's Fund, the Department for Economic and Social Affairs of the United Nations Secretariat, the World Health Organization and the regional commissions. In 1995, almost $440 million flowed through those multilateral organizations and agencies. In 1996, multilateral funds were provisionally estimated at $346 million, but a number of multilateral organizations have still not reported. UNFPA remains the most significant provider of population assistance, with almost $328 million programmed in 1996.

19. UNFPA core income, which increased over the period 1990-1995 from $212 million to $313 million, declined slightly in 1996 to $309 million. UNFPA supports a large number of programmes and projects throughout the developing world, and is the major source of population funding for other United Nations bodies. UNFPA multi-bilateral arrangements, whereby bilateral donors channel assistance through UNFPA to specific projects, have shown an increasing trend. Multi-bilateral funds stood at $14.2 million in 1995, and rose to $18.3 million in 1996. Provisionally, multi-bilateral arrangements through UNFPA will rise further in 1997, to reach $30 million.

C. Trends in multilateral loan assistance

20. The development banks, which provide loans to developing countries, are an important multilateral source of funds for population assistance. Their contributions are treated separately because they are in the form of loans rather than grants and must be repaid. The banks' projects reflect large blocks of loan agreements made in a single year but intended to be expended over several years. Multi-year commitments are recorded in the year in which they are approved.

21. In fiscal 1995, the World Bank made available loans of $448 million for population assistance, and in 1996 that total increased to $509 million, the largest amount the Bank earmarked for population activities in any fiscal year (see fig. V). Of that total, $253 million were International Development Association (IDA) loans made at highly concessional rates, and $256 million were International Bank for Reconstruction and Development (IBRD) loans made at rates closer to those prevailing in the market. In addition, the World Bank reported an expenditure of just over $8 million to intermediate donors as grants for programmes in population and reproductive health.

22. In fiscal 1997 (year ending 30 June 1997), the value of World Bank loans in the area of health, nutrition and population fell to $940 million, down from $2.3 billion in fiscal 1996. Although those totals have not yet been broken down by sub-sector, the preliminary estimate of 1997 lending for population and reproductive health projects is $230 million, less than half the 1996 total.

23. Traditionally, development loans for population have been counted as an element of total international assistance. However, the IBRD loans of the World Bank, are not grants but commercial loans that must be repaid with interest. On the other hand, the IDA loans of the World Bank, are in large part grants: they usually carry a long grace period, zero interest and a long term (35-40 years) for repayment of the principal.

Figure IVc
Donor assistance to UNFPA core resources, 1995-1997

(In terms of local currency, 1995 = 100)

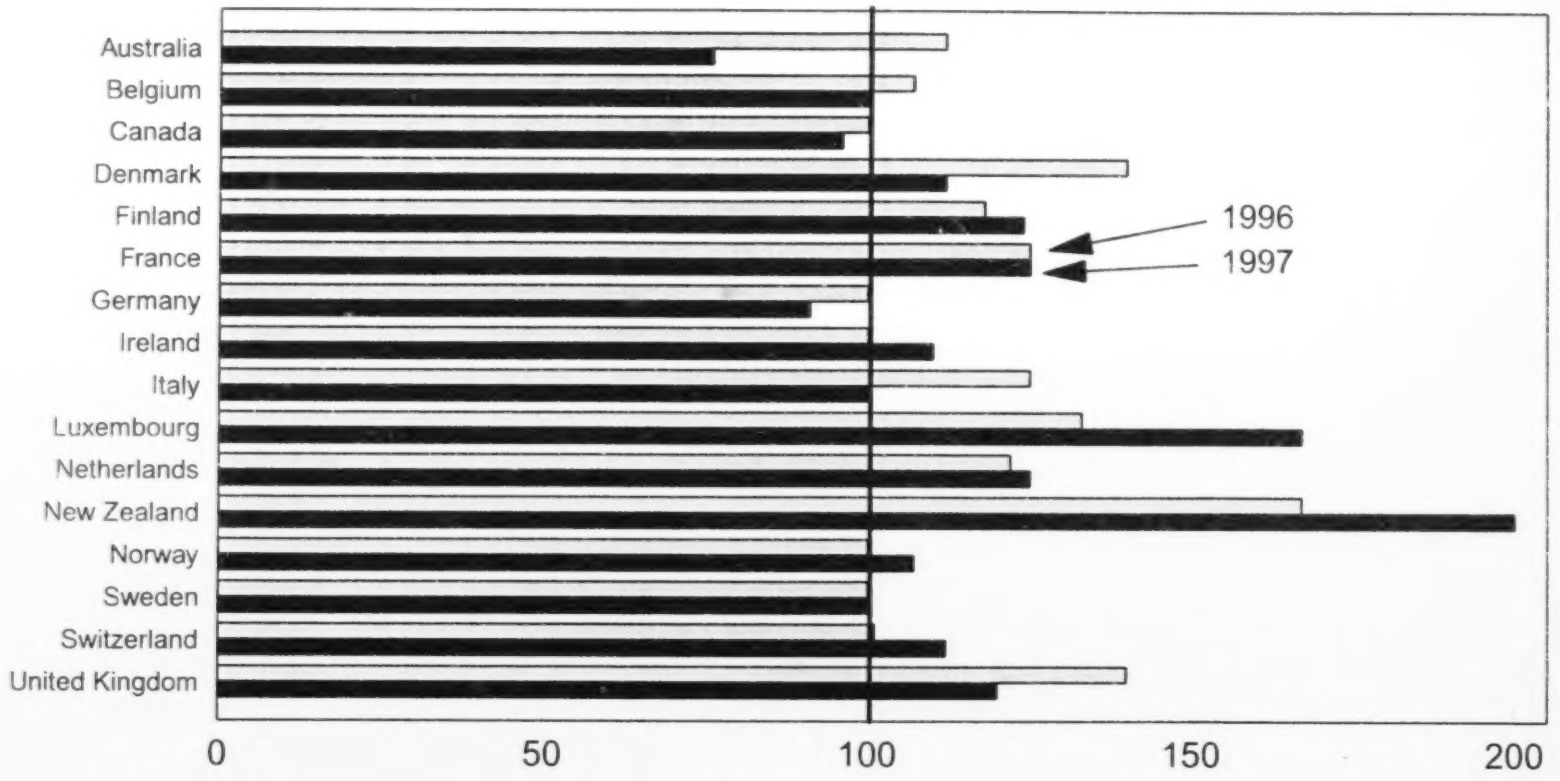
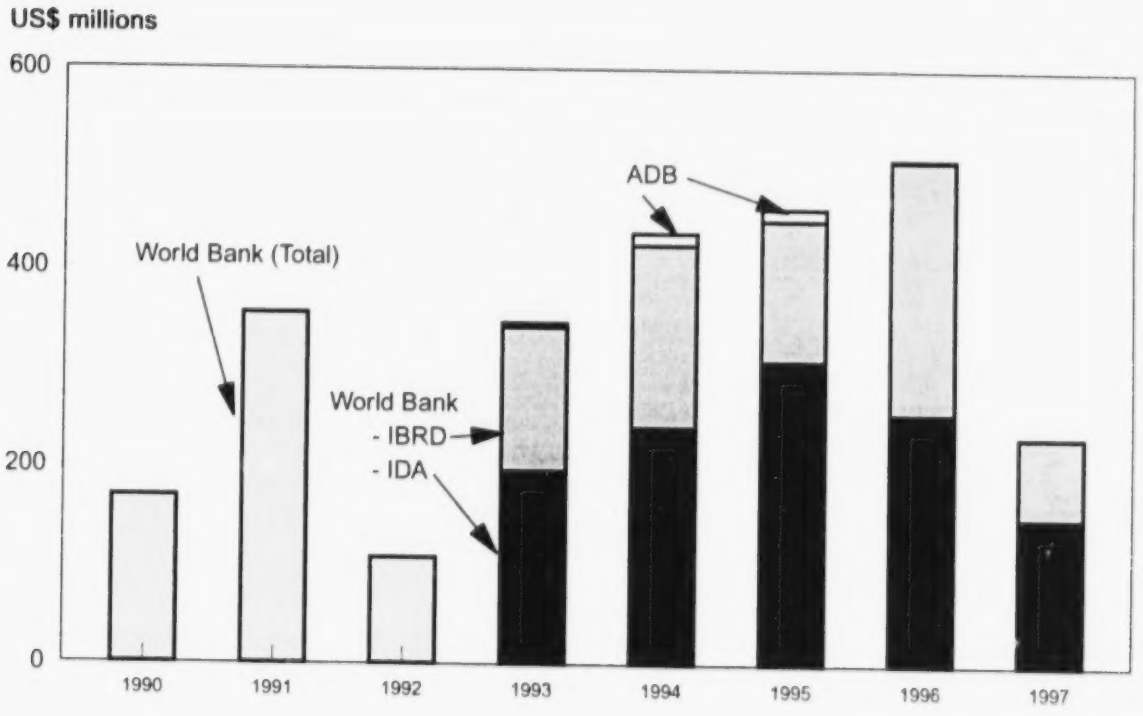


Figure V
Trends in multilateral development loans for population



Note: 1997 data are provisional. ADB data for 1997 not available.

24. Other regional development banks that provide loans for population projects include the Asian Development Bank (ADB). ADB made available $12 million for population assistance in 1995 but reported loan activity of only $1 million in 1996. The Inter-American Development Bank (IDB) reported that although support for family planning and basic reproductive health forms a part of many of their loans to the health sector, it is impossible to disaggregate the population components from the total loan amounts. In 1996, IDB approved lending of $484 million for public health programmes and services, part of which would be used for family planning and reproductive health.

D. Trends in private assistance

25. Another important source of international population assistance comes from the private sector, including foundations, private organizations and other international non-governmental organizations. In 1990, private sources provided $48 million for population assistance. The amount contributed by private sources has generally increased since then, and preliminary data for 1996 indicate assistance totalling $140 million. The organizations providing the most funds for population assistance in 1996 were the Ford Foundation, the Rockefeller Foundation, the MacArthur Foundation, the Hewlett Foundation and the Mellon Foundation (see fig. VI).

E. Expenditures by channel of assistance and geographical region

26. Besides being an important source of primary funds for population assistance, the non-governmental sector also constitutes a major intermediate conduit for population funds. In 1990, non-governmental organizations accounted for one third of total final expenditures for population assistance. As figure VII shows, the non-governmental organizations channel for project/programme execution has generally increased since then, and in 1996 non-governmental organizations served as intermediaries for almost half of all international assistance for population going to developing and transition countries.

27. During the 1990-1996 period, population expenditures for developing countries increased, with some fluctuations, in all regions of the world, as shown in figure VIII. During the past decade, more funds for population assistance were expended in Asia and the Pacific and sub-Saharan Africa than in any other region: those two regions currently receive over 70 per cent of all international assistance, and sub-Saharan Africa alone accounted for 37 per cent of all assistance in 1996. The proportion destined for countries in North Africa and West Asia has also increased recently. Latin America and the Caribbean and Europe, on the other hand, received proportionately less international assistance in 1996 than previously.

III. Domestic financial resources for population

28. Following ICPD in 1994, UNFPA made a commitment to comprehensively collect domestic flow data to augment its database on external donor assistance. Questionnaires were sent to 62 UNFPA representatives covering 154 countries in June 1997; in all, well over 600 individual questionnaires were sent to governmental and non-governmental organization bodies in those countries.

29. As of 5 November 1997, the cut-off date for preparing the present report, 53 countries had provided data on domestic resource flows for population activities (several others are in the pipeline); of those, 17 were in sub-Saharan Africa, 12 were in Asia and the Pacific, 15 were in Latin America and the Caribbean, four were in Western Asia and North Africa, and five were in Eastern Europe. Those responses represent over 60 per cent of the total population of developing countries and countries in transition (excluding China). By region, the data reported on below cover 30 per cent of the population of Latin America and the Caribbean,[7] about 40 per cent of sub-Saharan Africa, North Africa and West Asia, and over three quarters of Asia (excluding China) and countries in transition. An informal submission will be before the Commission that will provide a more complete picture of domestic resource flows than is possible to date.

Figure VI
Population assistance from private sources, 1994-1996

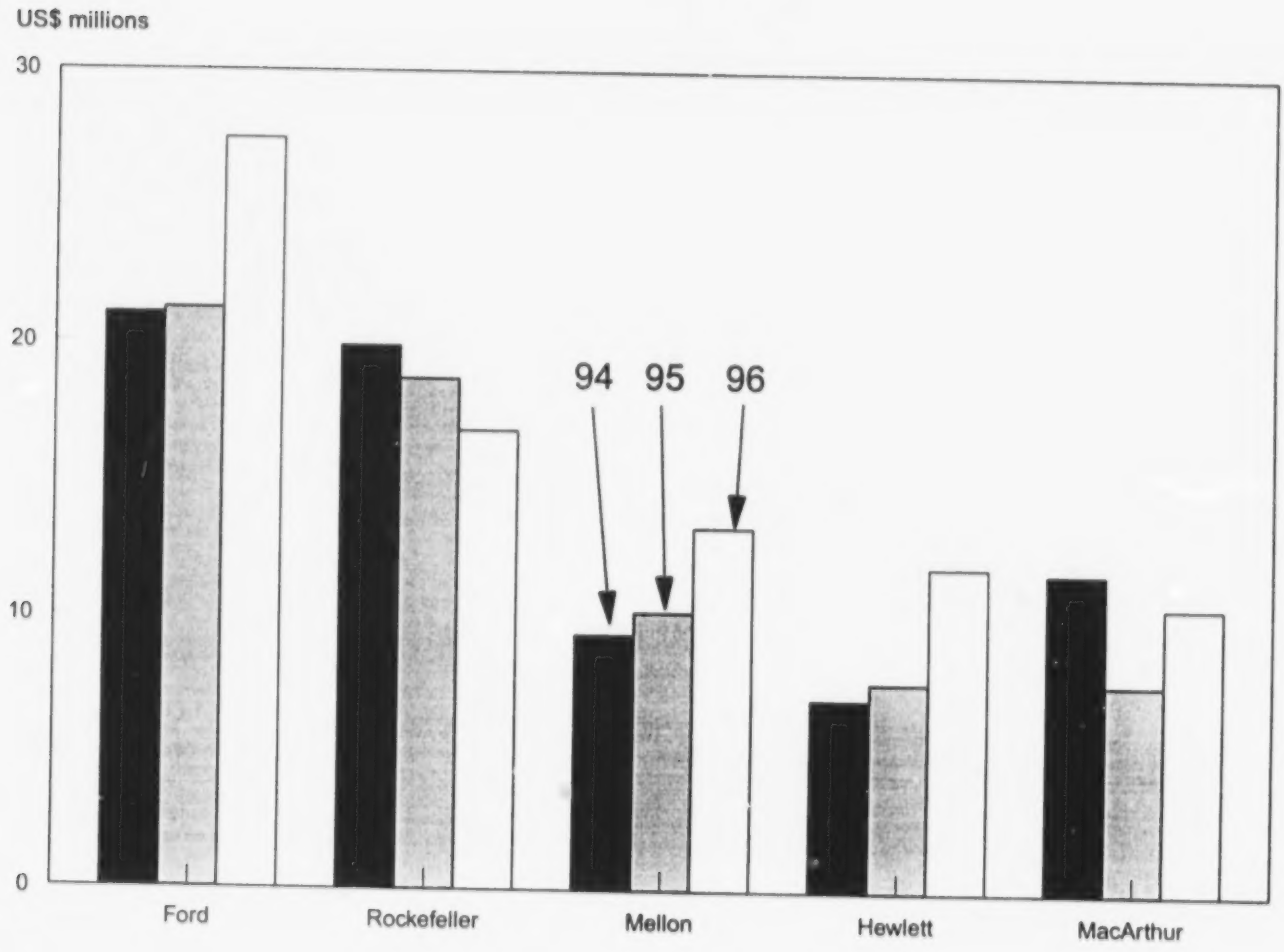
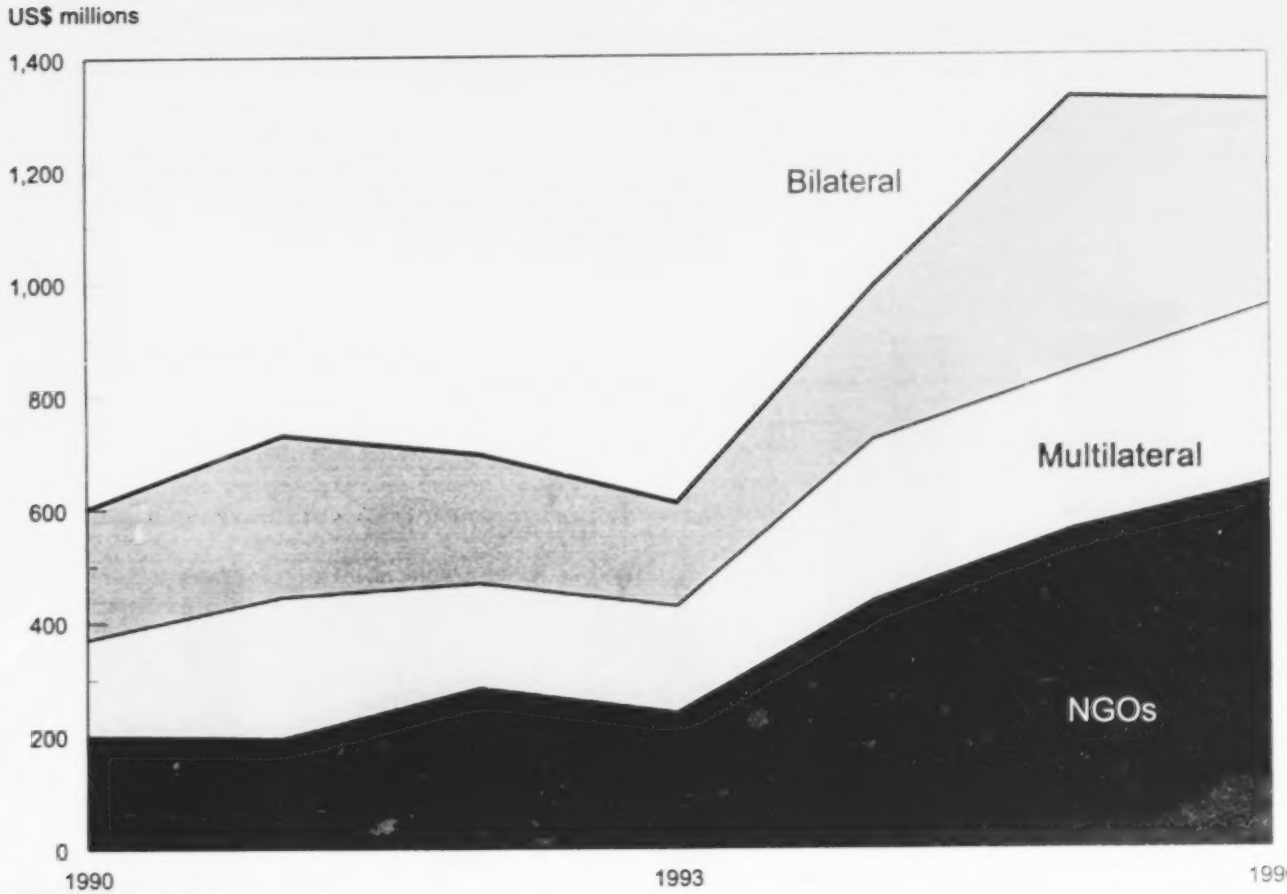
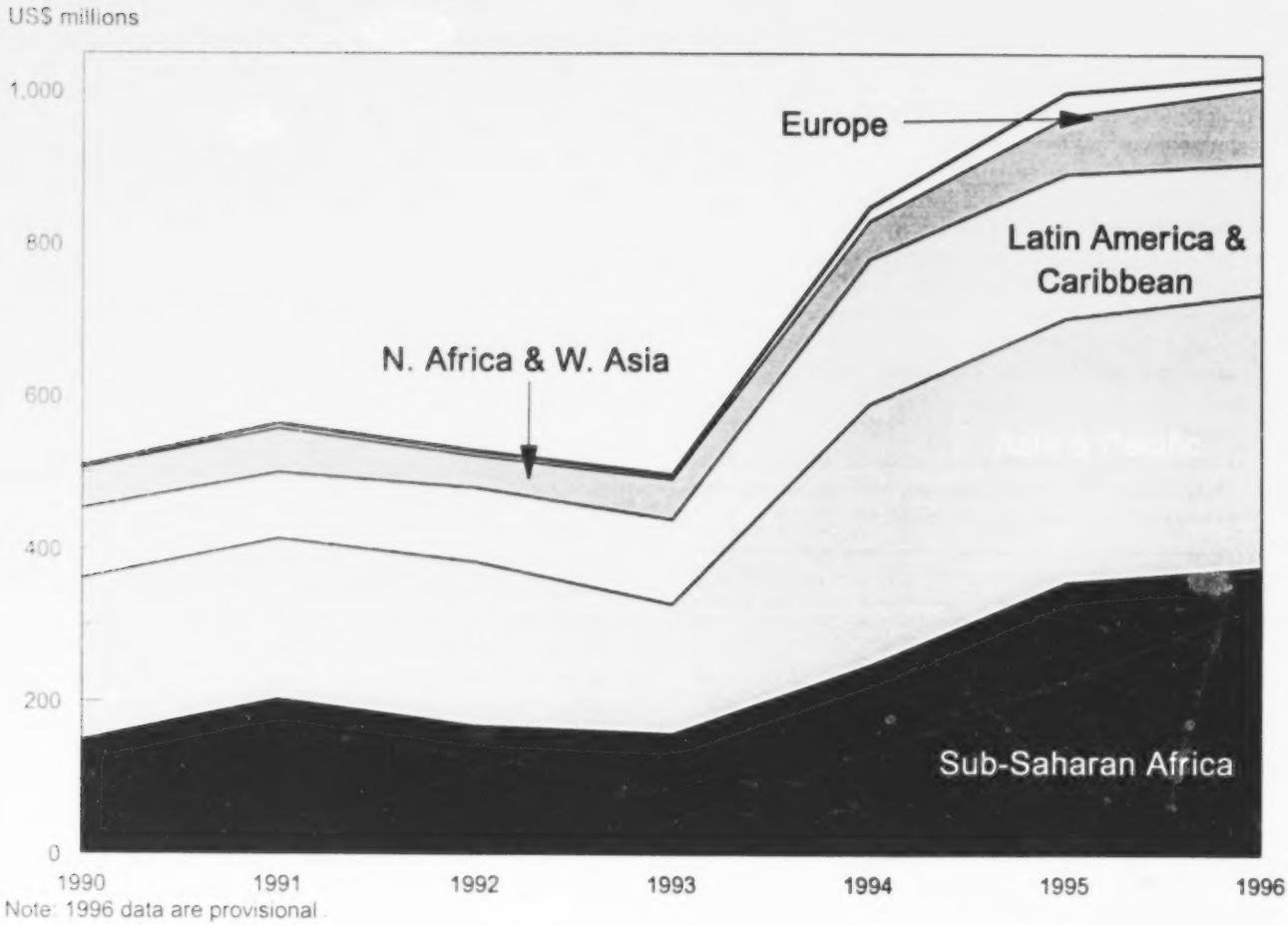


Figure VII
Population assistance by channel, 1990-1996



Note: 1996 data are provisional.

Figure VIII
Population assistance by region of destination, 1990-1996



Note: 1996 data are provisional.

A. Estimated total domestic resource flow (Governments and non-governmental organizations)

30. Table 1 contains estimates of domestic financial flows from two major sources: Governments and non-governmental organizations. A third major domestic source of funding, the private sector (individuals and households), cannot yet be included due to insufficient data. Without considering private financing, the global figure estimated for domestic resource flows for population in 1996 for all developing countries and countries in transition is in the order of $7 billion as shown in table 1 (first column).[8] That provisional estimate is based on 1996 data from 53 countries, and is subject to revision upon receipt of data from other countries. Using an existing estimate of the proportion of private resources in the domestic total (14 per cent), a crude global total for domestic financial flows for population in 1996 is estimated at $8 billion.

Table 1
Government and non-governmental organizations expenditure for population in 1996: all developing countries and countries in transition

	Total domestic (Millions of US$)	*Total domestic (US$ per 100 people)*
Sub-Saharan Africa	200	37
Asia and the Pacific	5 300	91
Latin America and the Caribbean	1 100	231
North Africa and West Asia	300	89
Countries in transition	100	33
Global total	**7 000**	**88**

Note:
In the first column, 1995 estimates for China are included under Asia and the Pacific.

B. Government and non-governmental organizations per capita expenditures

31. As of 5 November 1997, 224 questionnaires on domestic resource flows had been received and processed from Government sources, and another 261 from national non-governmental organizations. Table 1 (second column) shows the results of that data-gathering exercise as of the above cut-off date. Sub-Saharan African Governments and non-governmental organizations, as expected, spend among the least on the ICPD programme — only about 37 dollars per 100 people. Countries with economies in transition also expend a low amount on ICPD-related activities. Countries in North Africa and West Asia spend about 89 dollars per 100 people, and countries in Asia excluding China spend 91 dollars. Latin America and the Caribbean distinguishes itself from the other regions in that countries spend about 231 dollars per 100 population on services related to the ICPD costed package. Taking all developing countries and countries in transition as a group, about 88 dollars per 100 population are expended domestically by Governments and non-governmental organizations on population activities.

C. Incomes of national non-governmental organizations

32. Table 2 gives a broad picture of both sources of non-governmental organizations income and the level of that income. Overall, almost two thirds of non-governmental organizations funding comes from international assistance, and the remaining one third comes in equal parts from national Governments and self-generated funding. At the global level, the amount of income of non-governmental organizations working in population is, on average, about four United States dollars for every 100 persons. As an additional domestic source of financial resources, those data show that non-governmental organizations have a relatively small impact compared to Government programmes.

33. As can be seen from the first column of table 2, in sub-Saharan Africa, Asia and the Pacific and North Africa and West Asia, Governments give little financial support to non-governmental organizations. In transition countries, non-governmental organizations receive about one fifth of their income from national sources, and non-governmental organizations in Latin America and the Caribbean receive over two fifths from Governments.[9] On the other hand, self-generated income — mainly through user fees and charitable gifts — is important in some regions, particularly North Africa and West Asia where two fifths of total non-governmental organizations income comes through that modality (see the third column of table 2). Non-governmental organizations

operating in sub-Saharan Africa, however, rely almost exclusively on international assistance.

34. The last column of table 2 shows the level of non-governmental organizations income compared to the target population, given in terms of United States dollars per 100 people. As can be seen, non-governmental organizations income per 100 population ranges from $1 in countries in transition to $20 in Latin America and the Caribbean. Overall, non-governmental organizations handle only about 5 per cent of total domestic funds available for ICPD implementation in developing and transition countries. Compared to government population programmes, non-governmental organizations activities in percentage terms are small-scale in Asian countries, where only about 2 per cent of funds are managed by such entities. In contrast, the action of non-governmental organizations is quite significant in sub-Saharan Africa, where they handle more than one quarter of all population funds.

Table 2
Domestic income of non-governmental organizations for population in 1996

	From national sources	*From international sources*	*Self-generated income*	*Total income*	*Income per 100 people*
	Percentages				*US$*
Sub-Saharan Africa	2	89	8	100	8
Asia and the Pacific	9	71	21	100	2
Latin America and the Caribbean	43	45	13	100	20
North Africa and West Asia	2	58	40	100	5
Countries in transition	19	68	13	100	1
Global total	**18**	**65**	**17**	**100**	**4**

Note

Row percentages may not add to 100 due to rounding.

D. Indonesia: a case study[10]

35. An in-depth study of Indonesia was undertaken in August 1997 as part of the UNFPA/NIDI resource-flows project. Seven such case studies are planned for 1997 and 1998 to explore in-depth issues of data quality, provide "reality checks" for the project's data-collection methods, investigate in greater detail other sources of financing (non-governmental organizations, private sector), and to see how the ICPD Programme of Action is influencing resource flows.

36. Broad findings from the present study include the finding that although external assistance played a significant role at the beginning of Indonesia's population programme, support from the Government now makes up almost 90 per cent of the programme's total cost. National non-governmental organizations, who are playing an increasing role in the provision of services, are highly dependent on external resources. Donor inputs are therefore still needed to support non-governmental organizations and also to foster South-South cooperation.

37. The evolution from programmes focused on family planning towards ones with more of a reproductive health approach is taking place as a natural process. The Government plans to continuously decrease its presence in the financing of population-related activities and let the private sector take up the slack. By the year 2000, 50 per cent of contraceptive services should be privately supplied, and the Government's involvement will eventually decline to 20 per cent.

38. The study estimated the costs of contraceptive use for private households in Indonesia. Out of a total private expenditure of $82 million in 1995, families spent $35 million for contraception at government clinics, and $47 million through completely private channels. Reported 1996 expenditures by the Government and non-governmental organizations in Indonesia for the ICPD package total $244 million. Households therefore account for a substantial proportion of the total expenditures — at least one quarter in Indonesia — clearly showing that private-sector spending must be taken into account when projecting total resource flows.

IV. Resource mobilization and resource requirements for the implementation of the programme of action of the International Conference on Population and Development

39. The ICPD Programme of Action estimated that in the developing countries and countries with economies in transition, the implementation of programmes in basic reproductive health services, family planning services, the prevention of sexually transmitted diseases (including HIV/AIDS), and population and development policy analysis would cost $US 17 billion by the year 2000. The Programme of Action recommended that approximately two thirds of the projected costs in developing countries would have to come from domestic resources, and up to one third — or $5.7 billion — would have to come from the international donor community. Those were taken to be global targets that did not necessarily apply at the regional or national levels.

40. In addition to the costed population package, the Programme of Action also calls for socio-economic development programmes designed to strengthen the primary health-care delivery system and child survival programmes, provide universal basic education, improve the status and empowerment of women, generate employment, address environmental concerns, provide social services and address poverty eradication through sustained economic growth.

41. Additional resources will be needed to support programmes that address those wider social goals. An important action in that regard is the 20/20 Initiative, under which donors would commit themselves to allocate 20 per cent of development assistance to improving basic social services while developing countries would also agree to allocate 20 per cent of their development budgets for the same purpose. The Governments of Norway and the Netherlands sponsored an international meeting at Oslo in April 1996 to discuss the operationalization of such agreements among interested countries. A follow-up meeting is planned for September 1998 in Viet Nam to take stock of progress in implementing the 20/20 concept. One concrete case that will be discussed at the 1998 meeting is the 20/20 compact in Namibia. A study of resources for basic social services recently completed in Namibia shows that both the Government's allocations and donor support have surpassed the 20 per cent level, leading to a balanced development.

A. Initiatives on resource flows

42. A number of initiatives to increase resource flows for the implementation of the ICPD Programme of Action have been undertaken by Governments and the international community in the three years since the ICPD. Only recent actions (those taken since last year's report, which made particular mention of initiatives begun by various donor Governments, including Japan, Germany, the United Kingdom, Denmark, the Netherlands and Australia) will be dealt with here.

43. A meeting with donors was organized by UNFPA in February 1997 to review progress since ICPD in mobilizing resources and to explore ways of increasing funding. The need to bring the private sector into the resource picture was emphasized by participants at the meeting. They also suggested that the fertility, mortality and health consequences of failure to reach ICPD resource targets needed to be carefully analysed and findings disseminated in order to better demonstrate to decision makers the vital need for increased resources. OECD/DAC members continue to attach great importance to population activities, as signalled in the recent strategy document *Shaping the Twenty-first Century: The Contribution of Development Cooperation*. A report issued by the DAC secretariat in August 1997, entitled "Will donors meet their Cairo commitments", reviews the rationale for increased international assistance for implementing the Programme of Action and serves as a wake up call to DAC members.

44. The Joint and Co-sponsored United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (UNAIDS) has initiated a global programme to monitor financial resources, both external and domestic, that are expended on HIV/AIDS prevention and treatment. Information from that new source will be helpful in obtaining better estimates of resources allocated to STD/HIV/AIDS prevention, one of the four major components of the ICPD package.

45. The European Union continues to expand its reproductive health assistance. Besides the $31 million cooperation agreement with UNFPA to support population programmes in Asian countries, the European Union is negotiating a commitment with India for a new reproductive and child health project valued at about $232 million. The European Union has also continued to

expand its link with UNFPA by reaching a number of multi-bilateral agreements for population projects in Latin America, Africa and Commonwealth of Independent States countries.

46. Given the adverse trend in resource flows in 1996, the Hewlett Foundation has taken the lead in forming an informal group of private philanthropic foundations with a special interest in assuring that sufficient resources will be mobilized for implementing the Programme of Action. One goal of the group will be to broaden the resource base by making non-traditional potential donors in the private sector aware of the need to reach ICPD goals.

47. In July 1997, UNFPA sponsored a meeting between donors, contraceptive manufacturers and developing countries to help expand commercial markets for oral contraceptives in developing countries. The discussion centred around how to combine the market-widening know-how of commercial firms with the need of the public sector to serve the lowest-income segments of the population.

48. UNFPA participates in the initiatives of the Secretary-General to expand contacts with the private sector in order to help improve burden-sharing and to support reform of the financing aspect of operational activities of the United Nations.

B. Further analysis of resource requirements

49. The ICPD Programme of Action calls upon the international community to assess on a regular basis the specific needs of countries in the field of population and development (para. 16.28). The Programme of Action provided global estimates of required resources, and a background document prepared for the ICPD estimated regional requirements. Efforts to improve information on requirements at the national level, however, are still needed.

50. Costing out specific components of reproductive health is still a major challenge to be faced as countries seek to adapt their programmes towards realizing ICPD goals. The World Bank and the World Health Organization sponsored an informal meeting to examine the role of financial and economic analysis on reproductive health project/programme development. The National Research Council (United States of America) recently released the major study *Reproductive Health in Developing Countries: Expanding Dimensions, Building Solutions*, which examines operational issues in detail and also discusses costs. Other initiatives include a Population Council programme that will help to better define operational components for improving quality of care for service delivery, prevention of the consequences of unsafe abortion, improving post-partum care and incorporating STD prevention into reproductive health care. Those and other initiatives are laying the groundwork for better estimates of resource requirements at the national level.

V. The data collection system on financial resource flows

51. UNFPA has expanded and made improvements in its data collection system since the last report to the Commission in 1997. In addition to monitoring international assistance for population activities and publishing its findings in the annual *Global Population Assistance Report*, UNFPA has begun a collaborative effort with NIDI to systematically gather data on domestic resource flows for population activities.

52. The UNFPA/NIDI collaborative project has resulted not only in enhanced coverage of international resource flows but also in the systematic collection of data on domestic Government allocations and expenditures, as well as non-governmental organizations funding for population activities, as documented in the present report. A database has been established for both international and domestic resource flows, which will be updated annually, providing a valuable information resource for the whole population community.

53. NIDI has established a home page on the Internet at:

http://www.nidi.nl/resflows

A meeting is scheduled for early 1998 at NIDI headquarters to discuss data collection and classification of the ICPD costed population package in preparation for the 1997 round of questionnaires, which will be used to collect 1997 resource flow data on both donor assistance and domestic flows. Parties interested in improving the data-gathering methodology, including donor organizations, are expected to attend.

Classification of population activities

54. The collection of resource-flow data in 1995 and 1996 has attempted to begin to reflect the ICPD perspective, introducing a classification of population activities that more closely follow the costed population package of the ICPD Programme of Action. Questionnaires for 1995 contained some categories of population activities not reported in previous editions, including separate categories reflecting expenditures for non-family planning basic reproductive health services, such as diagnosis, treatment, referrals and counselling services for sexually transmitted diseases, including HIV/AIDS; the prevention of STD/HIV/AIDS; and maternal, infant and child health care.

55. For the 1996 round of questionnaires, some further small modifications to the categories of population activity were made to accommodate the actual recording systems of agencies supplying those data. The principal change in 1996 was the exclusion of infant and child-care expenditures/allocations from the data-collection exercise. As a result, the 1996 data collection focused on the following four categories: family planning services; basic reproductive health services; STD/HIV/AIDS prevention activities; and basic research, data and population and development policy analysis.

56. It is important to underscore the fact that figures for 1995 and 1996 use slightly different classification components than figures for prior years. Those classification changes have occurred in the post-ICPD transitional years as systems for the recording of data have been updated to include the ICPD framework. As the difficulties of accurately attributing expenditures to the specific costed population package from broad reproductive health programmes become resolved, it will become possible to provide a consistent data series retrospectively adjusted to include a specific list of components.

VI. Conclusions

57. The present report analyses financial flows for population for 1995 and — provisionally — for 1996. In 1996, *international donor assistance* for population via bilateral, multilateral and private-sector channels, as well as from development banks, declined in dollar terms to about $1.8 billion, after having increased substantially in the two previous years. That decrease may be attributed partly to stagnant or declining overall ODA, and the difficult circumstances that several donor countries faced in 1996, as well as to changes in definitions used for data collection and a substantial decline in one donor country. On the other hand, the continued priority given to population assistance by several donors and the increasing proportion of ODA allotted to population are positive findings of the present analysis.

58. Information was also gathered on *domestic financial flows* in developing countries and countries with economies in transition. The data, although still incomplete at the time of drafting the present report, allow estimates to be made of the effort that developing and transition countries themselves are putting into implementing the ICPD Programme of Action. The domestic financial flows of those countries for assistance in the implementation of the ICPD Programme of Action, including Governments, non-governmental organizations and the private sector, were estimated at about $8 billion in 1996, and account for about 80 per cent of the total resources available for population programmes. That high overall percentage, however, conceals the far lower domestic share of domestic flows in poorer countries that are unable to generate the necessary resources. Thus, if India, China, Indonesia and Mexico are removed from the total, the domestic share of the remaining countries falls to a little more than half, so that that those countries depend on external sources for almost half of the resources needed to finance population programmes.

59. In total, the global resource-mobilization effort in 1996, using preliminary results from the data-collection exercise, is tentatively estimated at about $10 billion. Comparison of that amount with amounts estimated for previous years may be misleading, both because classification definitions have been evolving to better take into account the ICPD framework, and because the quantity and quality of 1996 resource-flow data are superior to what was available in previous years.

60. The present report represents a significant improvement in documenting financial flows at all levels, building on last year's report, which also improved on previous reports by analysing for the first time data on domestic resource flows. The improvement in the present report is due mainly to the new arrangement between UNFPA and NIDI to produce and update a database of financial flows. Although, as expected, the system has experienced some teething problems, that informational resource will progressively meet the international community's need for global financial flow data to monitor the ICPD Programme of Action.

61. It is encouraging to note the very positive population assistance policies of several donor Governments since ICPD, as well as their continued strength of domestic flows. The increased importance that many donors have given to population within the context of total ODA disbursements is another positive development in 1996. The decline in overall external assistance, however, is somewhat discouraging, especially after the optimism of last year's report, which described two years of promising growth in donor resources. Hopefully, 1996 will be seen as a respite, and increased mobilization of resources will be resumed towards the ICPD targets set for 2000. The successful implementation of the Programme of Action is still dependent upon higher levels of resources, together with increased efficiency in resource utilization. Sub-Saharan Africa, parts of Asia and least developed countries everywhere will need a larger and growing amount of resources from the international community, and all countries should increase their own resources for population and reproductive health.

Notes

[1] See *Official Records of the Economic and Social Council, 1995, Supplement No. ___* (E/1995/27).

[2] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex I.

[3] Information for Japan, a major contributor of population assistance, is not yet available for 1996, so that the present report uses Japan's 1995 level of assistance; estimates for France, Luxembourg, Portugal and Spain include only contributions to UNFPA for 1996 since their questionnaires have not yet been received.

[4] To date, data on assistance for STD/HIV/AIDS prevention for the United States are not available.

[5] Germany reported actual expenditures in 1996 of US$ 96 million, while reporting allocations (or commitments) of $US 127 million; for consistency, however, all donor amounts for 1996 are being entered into the resource-flow database as *expenditures*, and will be reported as such.

[6] 1997 income data for UNFPA are still provisional.

[7] Brazil's questionnaires are in the pipeline, but are not available for the present report.

[8] The estimation method used is straightforward. Figures taken from the final column of table 1 are multiplied by the total 1996 populations for each region and summed. Since the data for China were not received in time for inclusion in the present report, 1995 estimates were used and added to the Asia and Pacific region. The total expenditure amount for China (estimated in 1995 at $3.5 billion) was distributed to the four ICPD components in the same proportions as for the remainder of Asia. Moreover, the sum of US$ 471 million for radio and television advocacy efforts reported by the Government of Mexico was still not categorized or entered in the database at the time of drafting the present report. The lack of complete data and the simplicity of this method require that the preliminary estimates made here be treated cautiously.

[9] Although the great majority of non-governmental organizations income from national sources comes from the national Government, some small amounts may come from national foundations or unidentified sources.

[10] A separate report on the Indonesian case study will be issued by UNFPA; case studies in Egypt and Senegal will be carried out before the end of 1997.

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Progress of work in the field of population in 1997: Population Division, Department of Economic and Social Affairs

Report of the Secretary-General

Summary

The present report reviews the progress achieved by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat in implementing its programme of work in the field of population in 1997. It covers the activities of the Population Division in the subprogrammes dealing with the analysis of demographic variables at the world level; world population projections; population policy and socio-economic development; monitoring, review and appraisal, coordination and dissemination of population information; and technical cooperation in population. Other continuing activities of the Population Division are also described.

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I. Introduction

1. Population activities in the United Nations Secretariat are centred in the Population Division of the Department of Economic and Social Affairs. As described in the Secretary-General's Bulletin on the Organization of the Department of Economic and Social Affairs (ST/SGB/1997/9), the core functions of the Division are as follows:

(a) Providing accurate and timely data, information and analyses of population trends and policies; identifying new and emerging issues, and initiating studies thereof, in support of the Commission on Population and Development, the Economic and Social Council and the General Assembly, other intergovernmental bodies and the international community;

(b) Serving as substantive secretariat to the Commission on Population and Development, including the monitoring and review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development;[1]

(c) Promoting coordination among United Nations entities in the field of population;

(d) Preparing the official United Nations population estimates and projections, which serve as the standard figures on population for use throughout the United Nations system;

(e) Taking the lead in the development and maintenance of population information systems and networks;

(f) Providing advisory services to assist Governments in improving their institutional and technical capabilities for the analysis of population data and related information, the formulation of national policies and the implementation and evaluation of programmes;

(g) Preparing reports of the Secretary-General to the Commission on Population and Development, the Economic and Social Council, and the General Assembly;

(h) Preparing analytical reports, in-depth studies, background papers, briefing notes and talking points on population-related issues before the international community for the Secretary-General and his senior officials ;

(i) Maintaining contacts with non-governmental organizations and academic institutions throughout the world; organizing working groups, meetings of experts and symposia on population issues; and participating in seminars and professional meetings relating to the mandate of the Division.

2. The present report deals with the research and technical cooperation work and information activities carried out by the Population Division during 1997. The activities are grouped according to the subprogrammes of the programme budget for the biennium 1996-1997.

3. The Population Division has made every effort to implement the programme of work adopted by the Commission on Population and Development and endorsed by the Economic and Social Council and the General Assembly. The work programme for the biennium 1996-1997 was formulated and implemented within the basic framework set forth in the medium-term plan for the period 1992-1997, taking into account the recommendations of the International Conference on Population and Development (ICPD) and other relevant international conferences.

4. Delays in the implementation of programmed outputs continued during 1997 as a consequence of the measures taken by the Secretary-General in response to the financial situation of the Organization.

5. The Population Division of the Department of Economic and Social Affairs continued to collaborate closely with agencies, programmes and other bodies of the United Nations system in the implementation of the work programme and in connection with the follow-up activities to the International Conference on Population and Development. In addition, the Division maintained close collaboration with the United Nations Population Fund (UNFPA) in carrying out technical assistance activities within the technical support services/country support team system.

II. Analysis of demographic variables at the world level

A. Fertility and family planning

6. During 1997, work was completed on the study entitled "Evolving patterns of fertility behaviour in developing countries", which examines levels and trends in fertility as indicated by most recent data made available from censuses and surveys undertaken in developing countries. Data gathered for the study are also used to update two computerized databases for the monitoring and analysis of fertility and family planning situations.

7. The findings of the study show that during the period under review — from about 1970 to about 1990 — all but a very few developing countries experienced an overall decline in fertility. However, the timing of the onset, and the

pace and pattern of decline varied. With regard to the pattern of fertility, it is observed that age-specific fertility rates declined at all ages in nearly all the developing countries reviewed in the study. For countries that have reached a low level of fertility, a new pattern of fertility, similar to the one observed in the West, is emerging, in that childbearing appears to be concentrated in the central age groups of reproductive span.

8. A wall chart has been issued, entitled "World fertility patterns 1997", covering 167 countries and areas and 90 per cent of the population of the world. The wall chart depicts in a vivid manner the levels and trends of fertility in terms of total fertility rate, annual percentage change in the level of fertility and age-specific fertility rates. In addition, the wall chart displays patterns of fertility and changes therein in the form of graphs for all the subregions of the world. A global map exhibiting the levels of fertility in respective countries of the world is also displayed on the wall chart.

9. A recently issued study, entitled "Family building and family planning evaluation", uses a new approach to the analysis of fertility behaviour and the impact of family planning programmes on fertility. The methodology developed in the study was used to analyse fertility experience in 15 selected developing countries, representing various regions of the world. Results of the study show that as of the late 1980s, contraceptive use reduced total fertility rates in the 15 countries by between 0.8 and 4.8 children.

10. The Population Division of the United Nations Secretariat organized an expert group meeting on below-replacement fertility at United Nations Headquarters in New York from 4 to 6 November 1997. The purpose of the meeting was to get the view of experts on how fertility levels may evolve in countries which are already exhibiting fertility below replacement. Will they remain below replacement? Will fertility rise back towards or ever reach replacement? The experts examined recent fertility trends in those countries, determinants of below-replacement fertility, future expectations for fertility, consequences of sustained below-replacement fertility, and policy and programme options. The Population Division prepared two of the background papers for the expert group meeting, one on recent fertility trends in countries with below-replacement fertility and one on future expectations for fertility levels in those countries.

B. Mortality

11. A major activity of the Population Division in the area of mortality was the organization of a symposium on health and mortality in collaboration with the Government of Belgium, the municipal government of Flanders and the Population and Family Study Centre. The symposium, which took place at Brussels from 19 to 22 November 1997, addressed a variety of issues related to the health status and mortality risks of the adult population in developed and developing countries, as well as in countries with economies in transition. The topics discussed included the varying experiences of world regions regarding mortality, epidemiological and health transitions; the problems faced in measuring mortality levels and mortality by cause of death, particularly in developing countries; the various approaches to the measurement of health status and their limitations; the health and mortality situation in developed countries, countries with economies in transition and developing countries; and the relevance of risk factors underlying major causes of death for the formulation of health interventions.

12. Also in the area of adult mortality, the Population Division is undertaking a review of the state of current methodology to estimate adult mortality in countries with incomplete or deficient data. A preliminary review has been completed, which indicates that advances in indirect methods for the estimation of adult mortality are unlikely to yield, by themselves, a better set of estimates on the mortality of persons over age 10. It is essential to improve the availability and quality of the basic data if reliable estimates of adult mortality are to be obtained for the majority of developing countries.

13. Continuing the systematic compilation and analysis of data allowing the estimation of mortality in childhood, databases containing both the basic data available and the estimates derived from them have been compiled for the three developing regions: Africa, Asia and Latin America. The data set for each region is issued under the Child Mortality Database. That Database complements and expands the coverage attained in the series entitled Child Mortality by Sex. In preparing both Databases (the one referring to estimates by sex and that for both sexes combined), all the data available for each country have been included, together with appropriate references to their source and character. In addition, for each country the database contains the estimates derived from the data sets available, presented both in numerical terms and in graphs allowing an assessment of their overall consistency. Those Databases have been used as the basis for the preparation of the chapter entitled "Child mortality" of the *1998 World Population Monitoring Report*.

C. International migration

14. Two reports analysing specific aspects of international migration levels and trends are nearing completion. The first, entitled "Trends in the migrant stock", will include a detailed analysis of the estimates of trends in the migrant stock derived from information on the foreign-born and the foreign population enumerated by censuses. It will have a global and regional focus since the estimates obtained are more robust at the regional level than at the level of specific countries.

15. The second report, entitled "International migration in Asia", will include an analysis of levels and trends of various types of international migrants in the region. In particular, it will document the changing trends in the flows of migrant workers between Asian countries, as well as recent developments regarding the increasing levels of undocumented migration directed to the newly industrializing countries of Eastern and South-eastern Asia. Attention is also being given to the analysis of trends in the number of refugees in the region and of changes in their distribution by country of origin.

16. As a complement to the analysis of labour migration flows in Asia, a database including all the information available on such flows has been prepared. Issued under the title Labour Flows from Asian Countries, it compiles the statistics generated by countries of origin as a by-product of the control of worker migration.

D. Internal migration

17. An in-depth analysis of country-level estimates of rural-urban migration and estimates of the components of urban growth derived from intercensal comparisons is being completed, and will be issued under the title "The components of urban growth in developing countries". That report builds upon the general overviews of the estimates available that were prepared in previous years, and discusses changing trends in rural-urban migration since 1960 at the country and subregional levels.

III. World population projections

A. World population estimates and projections: the 1996 and 1998 revisions

18. Completion of the 1996 revision of world population estimates and projections was announced to the Commission at its thirtieth session. At that time the annex tables, the wall chart *World Population 1996*[2] and a computer database on diskettes had been published. Since then, the report *The Sex and Age Distribution of the World Population: The 1996 Revision*[3] has been published. The final report, *World Population Prospects: The 1996 Revision* has been sent for editing.

19. The *1996 Revision* contains an extensive analysis of recent demographic trends, with specific chapters dealing with population size and growth; fertility; mortality; international migration; the demographic impact of the acquired immunodeficiency syndrome (AIDS) in 28 countries; a detailed comparison between the results of the 1994 revision and the results of the *1996 Revision*; methodology; sources of data and demographic methods.

20. The Population Division has recently completed the updating of its long-range population projections. The report presents population projections for the world until the year 2150, based on the *1996 Revision*. There are seven projection scenarios in those long-range projections: the medium, high, low and constant fertility variants extend until 2150 the corresponding assumptions of the *1996 Revision*, while the high-medium, low-medium and instant replacement fertility scenarios are additional projections prepared to give a more detailed range of possible future courses of population growth. The projections are prepared for 8 large geographical groupings: Africa, Europe, Latin America and the Caribbean, Northern America, Oceania, China, India, and Asia excluding China and India. The previous set of long-range projections were based on the 1990 revision. The new long-range projections incorporate the extensive new demographic information which has become available between the 1990 revision and the *1996 Revision*.

21. Work is currently proceeding on the 1998 revision of the world population estimates and projections. As in the previous revision, the 1998 revision will present a century of demographic estimates and projections, incorporating an estimation period extending from 1950 to 1995 and four projection variants to the year 2050. A planned innovation for the 1998 revision will be an extension of age detail from an upper age limit of 80 years to a new upper limit of 100 years.

22. The above-mentioned innovation was discussed at an expert group meeting on projecting old-age mortality and its consequences held in 1996. In order to make that change, extensive work has been done on existing life-tables and projection programme. The underlying life-tables have been

extended to a level of life expectancy of 87.5 years for males and 92.5 years for females.

B. Urban, rural and city population estimates and projections: the 1996 and 1998 revisions

23. Preliminary results of the 1996 revision of urban, rural and city population estimates and projections were announced at the time of the thirtieth session of the Commission. The final results were published as annex tables and were also issued as databases in May 1997. The wall charts *Urban Agglomerations, 1996*[4] and *Urban and Rural Areas, 1996*[5] have been published. The report *World Urbanization Prospects: The 1996 Revision* has been issued as a working paper prior to its formal publication.

24. The report will provide an extensive analysis of the prospects of urbanization and city growth in the world; a description of the methodology used; and sources of data. Some of the major results emerging from the report are detailed below.

25. At mid-1996, 46 per cent of the world population were urban dwellers. Between 1990 and 1995, 59 million persons were added annually to the world urban population. About 80 per cent of the new urban dwellers were located in the less developed regions. According to those results, half of the world population will be living in urban areas by 2006. The world urban population grew at a rate of 2.4 per cent per annum between 1990 and 1995, a slower pace of urbanization than previously exhibited. Over three fifths of the world population will be urban by 2030, five years later than previously anticipated.

26. Tokyo is the largest urban agglomeration in the world, with 27.2 million residents in 1996, more than one and half times as large as the world's second agglomeration, Mexico City, with 16.9 million. It is followed by Sao Paulo (16.8 million), New York (16.4 million) and Bombay (15.7 million). The rest of the 16 mega-cities in 1996, which are defined as urban agglomerations with 10 million or more, includes Shanghai (13.7 million), Los Angeles (12.6 million), Calcutta (12.1 million), Buenos Aires (11.9 million), Seoul (11.8 million), Beijing (11.4 million), Lagos (10.9 million), Osaka (10.6 million), Delhi (10.3 million), Rio de Janeiro (10.3 million) and Karachi (10.1 million).

27. Planning for the 1998 revision of urban, rural and city population estimates and projections has begun. As discussed at the nineteenth session of the ACC Subcommittee on Demographic Estimates and Projections, there will be initial consultations with the regional commissions concerning data availability.

IV. Population policy and socio-economic development

A. Population policies

28. One of the major activities of the work programme in 1997 was the preparation of the questionnaire for the United Nations Eighth Population Inquiry Among Governments. With input from the regional commissions and a number of United Nations specialized agencies, a new questionnaire was drafted, which will be a crucial input to the review and appraisal process to be undertaken in 1999. In addition to a number of core questions from previous United Nations inquiries, the Eighth Inquiry contains a number of questions which will attempt to assess to what extent the Cairo consensus on women's reproductive health and rights has been translated into population policies.

29. In 1997, the study entitled "International migration policies" was revised and expanded and submitted for publication. The study aims at contributing to a better understanding of migratory problems and responses, by offering a comparative overview of policies in regard to migration for permanent settlement; labour migration; refugee and asylum seekers, and undocumented migration. In addition, it examines such issues as family reunification, nationality and citizenship; and policies in regard to economic, social, political and cultural integration of immigrants. The publication is expected to provide an important technical reference for the technical symposium on international migration being organized by the Working Group on International Migration of the ACC Task Force on Basic Social Services of All, and for future discussions of international migration in the General Assembly.

30. During 1997, the volume entitled *World Population Policies* was completed. The publication consists of a consolidated one-volume overview of trends in population policies for 190 countries. The volume includes data sheets showing trends in national population policies from 1976 to 1996 for each of the 190 countries, as well as an overview chapter, describing and analysing trends in population policy at the regional and global levels.

31. The sixth edition of the population policy database Global Population Policy Database, 1997 (GRIPP:1997) is due to be completed in the first quarter of 1998.

32. In addition, a database on population policies is currently being developed with the aim of providing access to information to a wider range of users, as well as facilitating cross-country and time-series analysis. It will integrate all data collected by the Population Policy Section that are currently available in computer format. The database is being developed using Microsoft Access, and will include a powerful and user-friendly search tool. A comprehensive description of the information contained in the database is also being prepared.

33. Based on material contained in the population policy data bank, briefing notes for the Secretary-General were prepared on population issues in 31 countries (Bangladesh, Belarus, Bolivia, Botswana, Burkina Faso, China, the Congo, Côte d'Ivoire, Denmark, Egypt, Finland, Germany, Haiti, Iceland, India, Indonesia, Iraq, Italy, Japan, Kuwait, Malawi, Norway, the Philippines, Poland, the Russian Federation, Sweden, the United Republic of Tanzania, Thailand, Uganda, Zambia and Zimbabwe).

B. Population and development

34. The Working Group on Projecting Old-Age Mortality and Its Consequences was convened by the Population Division in December 1996. Two reports based on its discussions were issued in 1997: "Projecting old-age mortality and its consequences" and "Future directions in research on the demography of ageing". In the light of the topics identified in those reports as needing further research at the international level, the Population Division has begun preparation of an updated demographic overview of population age-structures and population ageing.

35. The "Wall chart on basic social services for all", which was released during the Commission's thirtieth session in 1997, has been very well received. The Division made special efforts during 1997 to distribute the Chart, working with the Department of Public Information as well as with the agencies, programmes and funds that are members of the ACC Task Force on Basic Social Services for All. An Internet version of the Chart was developed during 1997.

36. Two outputs connected with the data bank on Population, Resources, Environment and Development (PRED Bank) were issued in their final form during 1997: "User's Guide to the Population, Resources, Environment and Development Data Base (PRED Bank, Version 2.1)" and "National trends in population, resources, environment and development: country profiles". Work on the PRED Bank was one of the areas affected by the funding crisis in the United Nations Secretariat. Planning work has, however, begun for the next version of the data bank, which is included in the programme of work for the 1998-1999 biennium.

37. The report "Government views on population and the environment" has been issued. The report reviews official governmental statements, national reports and the draft and final documents adopted at major intergovernmental conferences dealing with population, environment and development issues from the early 1970s through the International Conference on Population and Development in 1994. The review found that by the time of the International Conference on Population and Development in 1994, Governments expressing concern with population-and-environment imbalances included a substantial majority of the population of both developed and developing countries. The study had previously been issued in working paper form.

38. Ongoing work in the area of population and poverty has been reoriented and broadened to include a review of recent work relating economic and demographic trends. That work will be relevant to the theme of the *World Population Monitoring Report* for 1999, which will include attention to the interrelationships between demographic and economic trends, including poverty.

V. Monitoring, review and appraisal, coordination and dissemination of population information

A. Monitoring of population trends and policies

39. At its thirty-first session, the Commission on Population and Development will have before it a concise report on world population monitoring, focusing on health and mortality, with special emphasis on the linkages between health and development and on gender and age (E/CN.9/1998/2). This is the third annual report on a special theme derived from the Programme of Action of the International Conference on Population and Development, as proposed by the Commission at its twenty-eighth session.

40. The above-mentioned theme corresponds to the issues addressed in chapter VIII of the Programme of Action, together with relevant aspects of chapters IV, V, VI and XII.

41. The preparation of an expanded version of the report has also been completed, and the draft will be made available to the Commission as a working paper. The report

provides recent information on selected aspects of health and mortality, including levels and trends of mortality, child survival and health, women's health and safe motherhood, human immunodeficiency virus (HIV) infection and AIDS, primary health care, mortality and health policies, and issues related to health and development.

42. The report also contains a set of annex tables providing indicators of the current demographic situation in major areas and regions, as well as data on population size and growth, population distribution, and fertility and mortality levels in countries, major areas and regions.

B. Population Information Network

43. During the past year, the Population Division's Population Information Network (POPIN) project promoted the use of new information and communication technologies to extend access to and use of population information worldwide. Emphasis was placed on building capacities within developing country institutions and within the United Nations regional commissions.

44. POPIN's capacity-building efforts were undertaken in collaboration with the United Nations agencies, the regional commissions and non-governmental population organizations, and included sponsoring the creation of Internet World Wide Web sites and training in use of the Internet as a medium for the dissemination of locally produced population information and data. During 1997, POPIN sponsored the establishment of Web sites at the Centro Latinoamericano de Demografía in Chile, and in Costa Rica, Peru and Argentina. In Africa, global POPIN sponsored the creation of population Web sites in Ethiopia, Egypt, Ghana and Kenya. In Asia and the Pacific, the global POPIN Coordinating Unit provided technical assistance toward the establishment of a Web site for the Population Division of the Economic and Social Commission for Asia and the Pacific (ESCAP), and global POPIN and ESCAP jointly provided training towards the creation of Web sites in China, Thailand, India, Fiji, Korea and Indonesia. Global POPIN also continues to provide technical assistance towards the development of Web sites by the UNFPA country support teams in the Asia and Pacific region. In Europe, global POPIN and the Economic Commission for Europe Population Activities Unit sponsored the development of Web sites in Hungary, Latvia and Poland. POPIN also undertook the production of the Internet-accessible Worldwide Directory of Population Institutions. The Directory is searchable by institutional name, geographical location (region, subregion, country) and type of institution.

45. For countries and regions where the Internet is not yet available or readily accessible, the global POPIN Coordinating Unit and the United Nations Development Programme Division of Administrative and Information Services collaborated on the production of a CD-ROM version of the POPIN World Wide Web site. Two limited editions of the CD-ROM were produced. The first was prepared for the Asia and Pacific POPIN Internet Technical Workshop, held at Bangkok in November 1996; a second edition of the CD-ROM was prepared in October 1997 for display and use in the POPIN exhibit of an International Union for the Scientific Study of Population (IUSSP) meeting at Beijing.

46. The global POPIN Coordinating Unit also organized an exhibit of population software and information technologies at the above-mentioned IUSSP meeting held at Beijing in October 1997. The exhibit was a joint effort of global POPIN, the China Population Information and Research Centre, the Economic and Social Commission for Asia and the Pacific and UNFPA.

47. During 1997, the 1993-1997 work programme of the global POPIN Coordinating Unit was evaluated by an independent Consultant. The evaluation can be summarized by the report's final conclusion, which stated that the positive nature of the evaluation reflected the view of the Consultant that POPIN was breaking new ground in international information systems territory. The evaluation report was among the subjects of a meeting of the POPIN Coordinating Committee from 1 to 5 December 1997 in New York.

C. Publication and dissemination of research studies

48. The Population Division continues to publish the results of its research studies in a variety of formats to meet the needs of different audiences. They are widely disseminated to Governments; national and international organizations; research and educational institutions; individuals engaged in social and economic planning, research and training; and the general public. It also continues to develop and maintain databases and software, which are made available on magnetic tape and/or diskette(s). A list of the Population Division's publications and other material issued in 1997 is given in the annex to the present report.

49. The Population Division continues to receive and respond to numerous requests for population information from United Nations organizations, research institutions and individual scholars. It also provides background information to and participates regularly in international conferences and meetings of the inter-agency groups and professional societies. Information from the Population Division has appeared prominently in a number of publications and reports of other United Nations bodies and international conferences and meetings.

VI. Technical cooperation

50. The Population Division provided technical assistance services to 12 projects during 1997 in the areas of population and development training; institutionalizing analysis and research on socio-economic and demographic data obtained from population censuses, surveys and vital registration systems; population policy; and population and development. Such projects have been implemented in 10 developing countries in Africa, Western Asia and countries with economies in transition.

51. During 1997, technical support services specialists in the areas of population data analysis and research, population policies and development strategies, and training for population and development provided substantive support to the eight country support teams and to national projects. The specialists published six state-of-the-art papers in the areas of population and development training, linkages between population and education, and recent findings in population analysis and research. In addition, the specialists participated in various technical meetings, such as a thematic workshop on indicators (New York, 10-14 February 1997), the annual meeting of the Population Association of America (Washington, D.C., 26-29 March 1997) and the Twenty-Third General Population Conference of IUSSP (Beijing, 11-18 October 1997), where specialists presented papers on population and development curricula, and promoting family planning and fertility decline in Africa.

52. Furthermore, the technical support services specialists of the Population Division carried out various missions during 1997. A specialist visited the Sudan to develop a project document for the Population Studies Centre at Gezira University (29 April-9 May 1997) and to update the curriculum of the Programme in Population and Development to reflect the ICPD Programme of Action paradigms. A mission to Egypt (June 1979) reviewed the project design and assessed research outputs from a project implemented by the League of Arab States. A mission to Rwanda (10-24 July 1997) provided assistance in the analysis of the 1996 Demographic and Health Survey. A mission to Nicaragua took place (26 October-2 November 1997) to conduct a seminar for the Master Programme on Sexual and Reproductive Health (School of Medicine of the National University of Nicaragua) on the contribution of the ICPD Programme of Action to the subject of sexual and reproductive health. A specialist visited Pennsylvania State University to discuss the population activities of the United Nations (13 November 1997). A specialist visited the country support team at Addis Ababa and participated in the Tenth Anniversary Workshop of Addis Ababa University's Demographic Training and Research Centre, where he also served as a resource person. Finally, a mission to Yemen (December 1977) reviewed the lessons learned from two recent projects.

Notes

[1] See *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18).

[2] United Nations publication, Sales No. E.96.XIII.14.

[3] United Nations publication, Sales No. E.97.XIII.1.

[4] United Nations publication, Sales No. E.97.XIII.2.

[5] United Nations publication, Sales No. E.97.XIII.3.

Annex

Publications, expert group meetings and other materials prepared by the Population Division, 1997

Research studies

User's guide to the Population, Resources, Environment and Development Data Bank (PRED Bank, version 2.1). ST/ESA/SER.A/168.

International Migration and Development: The Concise Report. ST/ESA/SER.A/164. United Nations publication, Sales No. E.97.XIII.4.

International migration policies. ST/ESA/SER.A/161.

Reproductive Rights and Reproductive Health: A Concise Report (Reprint). ST/ESA/SER.A/157. United Nations publication, Sales No. E.96.XIII.11.

World Population Monitoring 1996: Selected aspects of reproductive rights and reproductive health. ST/ESA/SER.A/156.

Family-building and family planning evaluation. ST/ESA/SER.R/148.

Government views on the relationships between population and environment. ST/ESA/SER.R/147.

"Projecting old-age mortality and its consequences", report of the Working Group meeting held in New York from 3 to 5 December 1996. Working paper. ESA/P/WP.136.

National trends in population resources, environment and development: country profiles. Working paper. ESA/P/WP.134.

World population monitoring, 1997: issues of international migration and development: selected aspects. Working paper. ESA/P/WP.132.

Too young to die: genes or gender? Working paper. ESA/P/WP.126.

World urbanization prospects: the 1996 revision. Working paper.

Evolving patterns of fertility in developing countries. Working paper.

World population monitoring, 1998: health and mortality. Working paper.

Future directions in research on the demography of ageing. Working paper.

Expert group meetings

Expert group meeting on below-replacement fertility (New York, 4-6 November 1997).

Symposium on health and mortality (Brussels, 19-22 November 1997).

POPIN Coordinating Committee meeting (New York, 1-5 December 1997).

Wall charts

Basic social services for all, 1997. ST/ESA/SER.A/160.

Urban Agglomerations, 1996. ST/ESA/SER.A/163. United Nations publication, Sales No. E.97.XIII.2.

World Fertility Patterns, 1997. ST/ESA/SER.A/165.

Urban and Rural Areas, 1996. ST/ESA/SER.A/166. United Nations publication, Sales No. E.97.XIII.3.

Databases

Child Mortality Database.

Child Mortality by Sex.

Database on Fertility Levels.

Database on Contraceptive Use.

Population, Resources, Environment and Development Data Bank (PRED Bank, version 2.1).

Databases on urban and rural areas and on urban agglomerations.

Periodicals

Population Newsletter, Nos. 63 and 64. The *Newsletter* is issued biannually to provide a wide readership with information on the programme activities of the Population Division; action taken by legislative bodies with competence in the population field; and meetings on population and related issues organized by the Population Division and other United Nations bodies, as well as recent and forthcoming publications of the Population Division.

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Item 5 of the provisional agenda*
Programme questions: programme of work for the biennium 1998-1999

Programme of work in population for the biennium 1998-1999: Population Division, Department of Economic and Social Affairs

Note by the Secretary-General

1. The Commission on Population and Development has before it for consideration at its current session the programme of work in population for the biennium 1998-1999. The programme of work was prepared under the medium-term plan for the period 1998-2001, adopted by the General Assembly in resolution 51/219, section I.

2. The programme of work has been prepared in accordance with the guidelines set out in General Assembly resolutions 3344 (XXIX), 3345 (XXIX) and 39/228 and Economic and Social Council resolutions 1986/7, 1989/92 and 1991/92, and within the framework of programme 7 of the medium-term plan for the period 1998-2001.[1] It also follows upon the work programme approved by the Council in resolutions 1979/33, 1981/29, 1984/4, 1985/5, 1987/71, 1989/93, 1991/92 and 1994/2 and decisions 1995/236, 1996/234 and 1997/220, and takes into account the Programme of Action adopted by the International Conference on Population and Development, held in Cairo in September 1994,[2] and endorsed by the General Assembly in resolution 49/128.

3. The programme of work has been designed to undertake follow-up activities relating to the International Conference on Population and Development: carry out research of the highest priority at the global level; disseminate research findings in the most effective manner possible; and provide substantive support for technical cooperation projects in the field of population. Relevant extracts from the programme budget for the biennium 1998-1999 of the Department of Economic and Social Affairs are presented in document E/CN.9/1998/CRP.1.

* E/CN.9/1998/1

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Notes

[1] *Official Records of the General Assembly, Fifty-first Session, Supplement No. 6* (A/51/6/Rev.1).

[2] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1.